P.O. Records, **Division of Vital** To the Hospital or Attending within 24 hours efter death.
To the Funeral Director: Atte completely filled in by the fune

be executed

68760

Baltimore, Maryland 21215-0036

State Registrar

31. Date filed (Month, Day, Year) NOV 2 1 2005

32. ggistrar's Signature

diene 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rock Heights Avenue

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Division of Vital Records, P.O. Box 68760,

	1.	For State Registrar		State of	Maryland		artment of I <i>tificate of</i>		and Mental H	ygien Reg. N		37502
sician	1.		e (First, Middle, La d Leonard	•					2. Date of I Month NOUL N	1 D	8,2005	3. Time of Death
edical miner	1	. Facility Name (i		eral 1	tospita Age (In yrs. Ias	al	4b. City, Town, of Bully	noce		40	c. County of Dea	th thplace (State or Foreigr
ral tor		214-54-	3257	1 M 2□F	55	Yrs.	Months Days	Hours	Min. (Month, I July	Day Year	950	ountry) unk
	-	sual Residence o a. State	10b. County		10c. City, 7	own or Lo	cation					10d. Inside City Limits
ctor		MD				Balti	Lmore					1√ Yes 2 No
Director	10	e. Street and Nu	mber				10f. Zip Code			10g. C	itizen of What Co	ountry?
eral	-	601 S.	Charles S	<del></del>	ent Ever in U.S.	13 1		21230	igin? (Specify Yes or !	No-	USA 14. Race - Ame	erican Indian
notes.  To Be Completed by Funeral Director			ried 2 Married	Armed Ford 1 Tes 2 If Yes, Give Year or Dat	es? No	1	f Yes, specify Cub 1 ☐ Yes 2 ☑ No	an, Mexica Specify	n, Puerto Rican, etc.)		Black, Whit	te, etc.
eted		(Soe	15. Decedent's E			16a. Deced	dent's Usual Occu kind of work done	oation during mos	st of working unk	16b. l	Kind of Business	/Industry un
Completed		Elementary/Seconk	ondary (0-12)	College (1-4	tor 5+)	lite.	DO NOT use retire	d)				
Be C			(First, Middle, Last	)	'		unk	18. Moth	er's Name (First, Midd	le, Maide	en Sumame)	un
2	1	9a. Informant's N	lame/Relationship (	Type, Print)	-	19b. Mailir	ng Address (Stree	and Numb	er or Rural Route Num	ber, City	or Town, State,	Zip Code)
	_		General	Hospital				venue	Baltimore	-	21202	T 0
	20	a. Method of Dis 1 □ Burial 2 4 □ Donation	sposition ☐ Cremation 3 [ 5 <del>[ Other</del> (Speci	□Removal from Si	cem	etery, crer	sition (Name of natory or other pla	сө)	Date	20c. l	Location - City or	Town, State
Aedical Examiner	Ir dd re	shock, or hear mmediate Calles isease or conflict esulting in death) equentially list or any, leading to it ause. Enter Undiause (Disease on attinitiated event esulting in death)	art failure. List only (Final on onditions, mediate ertying r injury s	a. Seps Due to (o b. Due to (o	ch line.	nce of): 2012 ( ance of):	er the mode of dy		cardiac or respiratory	arrest,		Approximate Interval Between Onset and Death
Physician/Me	2	F FEMALE: 3b. Was deceder in the past 12 1 Yes 2 9 Unknown	2 months?	1 Live bir	ome of pregnanc th 2 ☐ Fetal de nt at time of deat vn	eath 3	Ectopic pregnanc Other (specify)	у			23d. Date of de Month	livery Day Year
ompleted by	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	art 11. Other signi Diabete Decubi-	ificant conditions SMEIII FUS UI	contributing to deal HUS Hyp LERS, 1	e 2, H Malnu	epat frit	nderlying cause gr itis C, its	ven in Part Hage	24a. Wi	Yes 2 as an topsy forme 12	24b. Were at prior to death?	o the cause of death?  robably 4 punknown  utopsy findings available completion of cause of
BeC	2	5. Was case refe examiner?	rred to medical		<b>,</b>				e of Death (Check only			
Certification: To	2	1 ☐ Yes 2 ☐ 7. Manner of Dea 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide		28a. Date of (Month)	Injury 28 Day Year)	VOutpatier  Bb. Time of Injury  e, farm, str	f 28c. Inju	ry at	28f. Location	e how inju	ury occurred and Number or R	ural Route Number,
al Cert		4  Homicide		bullan	g, etc. (Specify)  pest of my knowle	edge, deat	h occurred at the t	me, date a	nd place, and due to the	own, Sta		s stated.
edical	L	(Check only one)			sis of examination				ath occurred at the tim			
W		9b. Signature and	d title of certifier  Muli	ddug	four		29c. Licen	se number 55.	5	29d. D	ate signed (Mont	th, Day, Year)
State		0. Name and add  No hor  1. Date filed (Mo.	nth, Day, Year)	addugo	of death (Item 2 UVU, M gistrar's Signatur	113.4	o Mar	ykane	d Genera	l	Hospi-	tal
gistrar	À.,		NOV 1 9	A A A A	lación d	de A	poste					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			Amend Item #19	b Per Fl					Death		Reg. No	05	3 7 5 0 3
	Physicia /Medic	an	1. Decedent's Name (First, Mic							Month 11-18	Day	Year	5:40 AM
	Examin		4e Facility Neme (If not institu		end number) RSING	HOME		1	4b. City, Town, or L BALTIMORE	_	h 4c. County	of Death	
	Funeral Director		5. Social Security Number 215 · 24 · 2916	6. Sex 1 M 2	7. Ag	e (In yrs. last bi	irthday)	If Under 1 Year Months Days		8. Date of Bir (Month, Da	th iy, Year) 1925	9. Birthplace Country)	(State or Foreign
	land		Usuel Residence of Decedent 10a. State 10b. Cour	nty		10c. City, Tow	vn or Loca	tion				10d. I	Inside City Limits
	e Mary	ctor	MO	NA		BALTIN	NORE						1⊠(Yes 2□No
	with the	Director	10e. Street and Number	AVEN	116			10f. Zip Code	20		10g. Citizen of V	Vhat Country? SA	
20	n 72 hours after death with the Maryland "naturel", or items 23a or 28a-f show aftest Examinet mast be notified at	by Funeral	802 WALNUT  11. Marital Status  1 Never Married 2 N  3 Widowed 4 Proposed	12. Wi An larried 1 [	as Decedent med Forces? Yes 2 27 Yes, Give ear or Detes:				Hispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No Rican, etc.)		e - American li k, White, etc.	
2-0	72 hour	ted b		tent's Education		16e	e. Deceder	nt's Usual Occup	pation during most of work	(ina	16b. Kind of Bu		
Maryland 21215-0020	c <u>s</u>	Completed	Elementary/Secondary (0-12		ollege (1-4or 5	5+)	life. DC	NOT use retire	d)	9	SOCIAL	SFAIR	ITU
d 2	Hygin H	Be Co	12 / H GRADE 17. Father's Neme (First, Midd	lle, Lest)	NIA			LEXIC	18. Mother's Nam	e (First, Middle			
ylar	should be and Mantal marked or umatic eve	ToB	JOSEPH COGER						BERTHA	GROSS	Ch. a. Taura	Ctata Zia Car	do)
Mar	47 th 22	- 1	19a. Informant's Name/Relation DONNA MONK	7		Ä	818	Address (Street Meadows 11014166	t end Number or Ru.	Randall	stown, M	1. 211	.33
Baltimore,	Pages 1 nant of Ha ant: If iten ury or oth		20a. Method of Disposition 1   Disposition 2 □ Crematic Donation 5 □ Other	on 3 □Remov		20b. Place of comete	ery, crema US	ion (Name of tory or other pla	1		BALTIM		
Balt	permit. Pag Department Important: I eny Injury o	I	21. Signature of Funeral Servi	$C \square$			515	BALTO.	BSS OF FACILITY GREENE FL NATU PIKE	BALTO.	MD 212		
	Physician /Medical		23a. Part1. Enter the disease shock, or heart failure. It Immediate Cause (Final disease or condition resulting in death)	, or complication list only one cau	ns that caused use on eech li		re (	demo	untia	or respiratory a	arrest,	Inte	proximate erval Between set and Death
Box 68760,	The law requires that the death certificate be executed at has been signed by the attending physician and page 2 should be detached for use as the bunal-transit	n/Medical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last	6		Due to (or as a							
	a death the atte	Physician/M	Part II. Other significant cond	litlons contributi	ing to death b	out not resulting	in the und	erlying cause gi	iven in Part I.	23b. Did	tobacco use co	ntribute to the	e cause of death?
, P.O	res that tha der signed by the a 1 be detached f		HTW							1 🗆	Yes 2□ No	3 Probabl	ly <b>4 Conknown</b>
of Vital Records,	w requires s been sign 2 should be	Completed by	failore	2 TO T	hive					24a. Was	s an autopsy ormed?	availat	autopsy findings ble prior to etion of cause th?
<u>=</u>		Com	DVT							+0	Yas 2	1 □ Y€	es 2 No
Vita	Physicien: The triticata haranticata haran	Be	25. Was case referred to med examiner?	lical Hospit	al: 1 □ Inpatio	ent 2 ER/C	Outpatient	3□ DOA OI	26. Place of Dea		one)idence 6 □Oth	er (Specify)	
ion of	<b>€</b> ₹ <b>=</b>	atlon: To	27. Manner of Deem Natural 5 Per 2 Accident	nding estigation	a. Date of Inju (Month, De	iry 28b.	. Time of Injury	28c. Inju			how injury occur		
Division	To the Hospital or Attending Ph within 24 hours after death.  To the Funeral Director: After thi completaly filled in by the funeral	Certification:	4 ☐ Homicide det	emmod	building, et	jury - At home, t c. <i>(Specify)</i>				City or To	(Street and Numb own, Stete)		
	n 24 hou n 24 hou ne Funer pletaly fil	Medical	29a. Certifier (Check only one)	cai Examiner: C	: To the best On the basis o and manner st	f examination e	ge, death o and/or inve	occurred at the t stigation, in my	ime, date and place opinion, death occu	, and due to the rred at the time	cause(s) and ma , date and place,	anner as state and due to the	d. e cause(s)
D	Voithi To th	Σ	29b. Signature end title of cer	erd f	Allend	hoy M	19	0	150303		29d. Date signe	21/	
			30. Name and address of personal Rodolfo FE	rnend	ted cause of c	deeth (Item 23e	) (Type, Pr	eden?	in Rd st	e162	Ceton	sulle,	21228
	Sta Regist	_	31. Date filed (Month, Day, You NOV 2		32 negisti	rar's Signature	Apa	de					

Registrar DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 9:37 P M **Physician** Danie Mar. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NA Himore VA Hospital If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5 Social Security Number 8. Date of Birth 6. Sex **Funeral** 216-68-4099 Usual Residence of Decedent Min 1□M 20F Days Hours Director death with the Maryland 10h County 10c. City, Town of Location 10d. Inside City Limits Item 27 is marked other than "naturel", or Items 23s or 28s-1 show other treumstic event, the Medical Examinar must be notified at Baltimore 1 es 2 No **Funeral Director** 10g. Citizen of What Country? 10f. Zip Code 12. Was Decedent Ever in U.S. Amped Forces? ↑ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours efter to Department of Health and Mental Hygiene. Important: if them 27 is marked other than "naturel", or iter any injury or other treumatic event 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Blac þ 3 ☐ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NQT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Eather's Name (First, Middle, Last) Mother's Names/First Middle tevenson **71246** 20b. Place of Disposition (Na Date State 20a. Method of Disposition Oc. Location - City or Town. Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Stony ure of Fineral Service License 23a. Part1. Ento the disease, or complications that caused the death. Do not enter the mode of dying su shock, or heart failure. List only one cause on each line. mD 21133 Approximate Interval Between Onset and Death ch as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Preuson Sequentially list conditions, Tarry, loading to mini adiata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Funerei Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 ☐ Fetel death in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 1 ☐ Yes 2 ☐ No 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? Yes 2 ANo 1 Yes 2 No 1 Yes To the Hospitet or Attending Physician: within 24 hours after death.

To the Funerel Director: After this certifica 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 2 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No М 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) AU4176435616776 2001 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar

OAN I FOOD MAN

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32. Registrar's Signature

Cribber

31. Date filed (Month, Day, Year)

ORIGINAL

St.

21201

			For State	State of Marylan	d / Department o		ental Hygien	2005	37505					
	Dhyojoi	an	Registrar  1. Decedent's Name (First, Middle, Las	(1)			2. Date of Death		3. Time of Death					
	Physicia /Medic	al	John H.  Aa. Facility Name (If not institution, give	Morris	4b. City, Tow	n, or Location of Death	NOV EMBER	c. County of Death	10 100 km					
	Examin	er	ST. AGNES	HOSPITAL.	13cel	to.		NIT						
	Funeral Director		213-30-3690	ex 7. Age (In yrs.	last birthday) If Under 1 Ye  Yrs. Months Da	ear If Under 24 Hrs. Lys Hours Min.	8. Date of Birth (Month, Day, Yea 26 2, 193	9. Birthp County	lace (State or Foreign try)					
	yland Nor		Usual Residence of Decedent  10a. State 10b. County		y, Town or Location			1	0d. Inside City Limits					
	with the Maryland is or 28a-f ahow	Director	Md • W/A	- D	altimore	ia.	10g. C	Citizen of What Cour	1 X Yes 2 □ No					
	23a or	al Dir	310 Edgew	ood St.	á	21229		U.S. A	•					
40	ter dea	Funeral	11. Marital Status 1 □ Never Married 2 1 Married	12. Was Decedent Ever in U. Armed Forces? 1 \ Yes 2 \ No If Yes, Give		of Hispanic Origin? (Spec Cuban, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Americ Black, White,						
0036	72 hours after c "natural", or iter	by	3 Widowed 4 Divorced	Year or Dates:	1 Yes 2 1		4.0h	Specify: Ba	ck					
215-		Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ducation ide completed) College (1-4or 5+)	16a. Decedent's Usual Od (Give kind of work do life. DO NOT use re	one during most of workin		Kind of Business/Ind	/.					
1213	iled withir Hygiene. ther then nt, the We	e Con	17. Father's Name (First, Middle, Last)		1abo		(First, Middle, Maide	Instruction Sumame)	to n					
/lanc	2 should be filed within and Mental Hygiene. is marked other than aumatic avant, the Manatic avant, the Manatic avant.	To Be	~ 1 11 1.	orris Sr.		Mable	Jennin	ngs						
Baltimore, Maryland 21215-0036	⊘ .a. = e	9	19a Informant's Name/Relationship (	Type, Print)	19b. Mailing Address (St.	101-	Route Number, City	or Fown, State, Zip	4					
ore,	ges 1 and to 1 to 1 Health If item 27 or other tr		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐		Place of Disposition (Name of cemetery, crematory or other	f Di	ate 20c.	Location - City or To						
II.	t. Pa tmen tant: njury		* 4 Donation 5 Dother (Specific	v) (Va	rrioon Forest	ddress of Fraguly	9 2005 E	ulp Ud	P.4					
Ba	permit. Departmine importa any injuice.		Coulton C.	Dorfan	1761 Uc	Culloh St.	Buldo.	We. 21						
	Physician		21. Signature of Funeral Service Licensee  22. Name and Address of Fastlin for Funeral Service  23. Name and Address of Fastlin for Funeral Service  23. Name and Address of Fastlin for Funeral Service  23. Name and Address of Fastlin for Funeral Service  23. Name and Address of Fastlin for Funeral Service  23. Name and Address of Fastlin for Funeral Service  23. Name and Address of Fastlin for Funeral Service  24. Name and Address of Fastlin for Funeral Service  25. Name and Address of Fastlin for Funeral Service  26. Name and Address of Fastlin for Funeral Service  27. Name and Address of Fastlin for Funeral Service  28. Name and Address of Fastlin for Funeral Service  29. Name and Address of Fastlin for Funeral Service  29. Name and Address of Fastlin for Funeral Service  20. Name and Address of Fastlin for Funeral Service  20. Name and Address of Fastlin for Funeral Service  20. Name and Address of Fastlin for Funeral Service  20. Name and Address of Fastlin for Funeral Service  20. Name and Address of Fastlin for Funeral Service  21. Name and Address of Fastlin for Funeral Service  22. Name and Address of Fastlin for Funeral Service  23. Name and Address of Fastlin for Funeral Service  24. Name and Address of Fastlin for Funeral Service  25. Name and Address of Fastlin for Funeral Service  26. Name and Address of Fastlin for Funeral Service  26. Name and Address of Fastlin for Funeral Service  27. Name and Address of Fastlin for Funeral Service  28. Name and Address of Fastlin for Funeral Service  29. Name and Address of Fastlin for Funeral Service  29. Name and Address of Fastlin for Funeral Service  20. Name and Address of Fastlin for Funeral Service  20. Name and Address of Fastlin for Funeral Service  29. Name and Address of Fastlin for Funeral Service  20. Name and Address of Fastlin for Funeral Service  20. Name and Address of Fastlin for Funeral Service  20. Name and Address of Fastlin for Funeral Service  20. Name and Address of Fastlin for Funeral Service  20. Name and Address of Fastlin for Funera											
	/Medical Examiner		resulting in death)	Due to (or as a conseq	quence of):		EASE.		Months					
<b>152</b>	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a conseq					1110					
/	be executed ician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a conseq	quence of):									
8760,	ate be ex hysician the buria	llcai l	(	d										
15° 8	eath certific attending p for use as i	n/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna				23d. Date of delive	ery					
JOHN. J s, P.O. Box	that the death ed by the atte detached for	Physician/M	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c 9 ☐ Unknown				Month	Day Year					
			Part II. Other significant conditions of DEMENTIA.	contributing to death but not res	sulting in the underlying cause	e given in Part I.	23e. Did tobacco	o use contribute to the						
MORRIS. S. Division of Vital Records,	aw requires as been sign 2 should be	Completed by					24a. Was an autopsy	24b. Were auto	psy findings available mpletion of cause of					
al R	ician: The lav certificate has rector, page 2						autopsy performed? 1 ☐ Yes 2 ☑	death? No 1 ☐ Yes	2 No					
Z Ž	Attending Physician: r death. sctor: After this certifica	To Be	25. Was case referred to medical examiner?  1  Yes 2  No	Hospital: 1 Minpatient 2	ER/Outpatient 3 DOA	26. Place of Death Other: 4 ☐ Nursing Hon	The second second second second second	6 □Other (Specif	y)					
o Lo	ding Pt h. After th funeral		27. Manner of Death  1 Natural 5 Pending 2 Accident investigatio	28a. Date of Injury (Month, Day Year)	28b. Time of 28c. Injury	Injury at 2 Work? 1 Yes 2 No	28d. Describe how in	jury occurred						
:0	ttendi death.	ca	3 ☐ Suicide 6 ☐ Could not b	00 Blood of Injury At h	ome, farm, street, factory, of		28f. Location (Street City or Town, Sta		al Route Number,					
Σ̈́	or A after Direction by	TT.	4 - Homicide											
Divi	Hospitel or Attend 4 hours after death Funeral Director: ely filled in by the i	ical Certification:	29a. Certifier 1 Certifying Ph	hysician: To the best of my knominer: On the basis of examina	owledge, death occurred at the attention and/or investigation, in	ne time, date and place, a my opinion, death occurre	and due to the cause and at the time, date a	(s) and manner as s	tated. the cause(s)					
Divid	i i i i i	Medical Certif	29a. Certifier (Check only one)  29b. Signature and title of certifier	hysician: To the best of my knominer: On the basis of examination and manner stated.	ation and/or investigation, in	my opinion, death occurre cense number	ed at the time, date a	(s) and manner as s and place, and due to Date signed (Month,	o the cause(s)					
Divi	To the Hospitel or A within 24 hours after to the Funeral Direct completely filled in by	edicai	29a. Certifier (Check only one)  29b. Signature and title of certifier  Mutuals. MD	hysician: To the best of my known in the basis of examination and manner stated.	ation and/or investigation, in 29c. Li	my opinion, death occurre cense number	ed at the time, date a	Date signed (Month,	o the cause(s)					
Divid	To the Hospitel or A within 24 hours after to the Funeral Direct completely filled in by	edicai	29a. Certifier (Check only one)  29b. Signature and title of certifier	hysician: To the best of my known in the basis of examination and manner stated.  MWLTA-VA  completed cause of death (Itel.	m 23a) (Type, Print)	my opinion, death occurre	29d. [	ond place, and due to place signed (Month,	Day, Year)					

State of Maryland / Department of Health and Mental Hygien 37506 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) . <sup>Day</sup>2005 Month Nov. Jean Elizabeth Mewshaw 19, Physician 3:45 A M /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 1044 Bell Avenue Burnie G1en Anne Arundel If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Sept. 22, 1927 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 216-24-7198 6. Sex **Funeral** Months 1 ☐ M 2 🖸 F 78 Mary land Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits the Maryland 10b. County 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28a-f show empty injury or other traumatic event, the Mactical Examinar must be notified at once. Glen Burnie 1 ☐ Yes 2 ☑ No Maryland | Anne Arundel Compieted by Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21060 1044 Bell Avenue USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian, 11. Marital Status Black White etc. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housewife Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be George Alexander Klein Nellie Ferrell 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) William H. Mewshaw (Husband) 1044 Bell Avenue, Glen Burnie, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition Cedar Hill Cemetery 1 
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 11/23/05 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Ecker <sup>22</sup> Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 237 E. Patapsco Ave., Balto., Md. 21225-1850 Kevin 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Monthy Physician resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Completed by Physician/Medical Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) P.O. Box 68760, as the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year ğ in the past 12 months? Month Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, page 2 should be 2 🗆 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yes certificate 1 Yes To the Hospital or Attending Physician: rector, 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 Inpatient 2 EN/Outpatient Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 Yes 2 No 3 DOA Certification: To funeral dir this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of De th 28b. Time of After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident investigation the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 4 Homicide filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai completely (Check only one) 29b. Signature and title of certifier Hospital Dr. Glan Su 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

	1- State of Maryland / Department of Health ar Certificate of Death	nd Mental Hy	/giene Reg. No. (	005	37507
sician edical	1. Decedent's Name (First, Middle, Last)  Martha Lee Merritt	2. Date of Domestin Month		Year , 2005	3. Time of Death
miner	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of		4c. Co	unty of Death	
	2618 Plainfield Road Dundalk  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24	Hrs. 8. Date of Bi		altimor	
ral tor		Min. (Month, D	ay, Year) 12,193	Coun	lace (State or Foreign try) th Carolina
To Be Completed by Funeral Director	10a. State 10b. County 10c. City, Town or Location			10	0d. Inside City Limits
Director	Maryland Baltimore Dunda	1k			1 ☐ Yes 2 ☒ No
	10e. Street and Number 10f. Zip Code			of What Coun	•
Funeral	2618 Plainfield Road 21222  11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, I			Race - Americ	
by Fur	1 □ Never Married 2 Married 1 □ Yes 2 No If Yes, Give 1 □ Yes 2 No Specify:	Puerto Rican, etc.)		Black, White, e	white
	15. Decedent's Education 16a, Decedent's Usual Occupation			of Business/Inc	
Completed	(Specify only highest grade completed) (Give kind of work done during most of life. DO NOT use retired)	of working			,
	12 Years Homemaker			n Home	
Be		s Name (First, Middle		тате)	
2	19a. Informant's Name/Relationship (Type, Print) (Husband) 19b. Mailing Address (Street and Number of Name)	eanna Bow		own State Zin	Code)
	Mr. Carl F. Merritt, Jr. 2618 Plainfield R				
	20a. Method of Disposition  1 □ Burial 2 ②Cremation 3 □ Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Locat	ion - City or To	wn, State
	`4 □Donation 5 □Other (Specify) Hilltop Service Corp. 1	1/21/2005	Tows	on, Mar	yland
	21. Signal are of Funeral Service Licensee  22. Name and Address of Facility Duda-Ruck Funer 7922 Wise Ave.				
	2 1 art1. Enter the disease. Complications that caused the death. Do not enter the mode of dying, such as ca shock, or heart failure. I list only one cause in each line.	ardiac or respiratory a	arrest,	and ZI	Approximate Interval Between
ı	Immediate Cause (Final disease or condition				Onset and Death
ı	resulting in death)  Due to (or as a consequency of):				
ē	Sequentially list conditions, if any, leading to immediate b. Any typical to to the sequence of):	2120	-		
Examiner	rany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.				
	resulting in death) Last Due to (or as a consequence of):				
dicai	d				
hysician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d	. Date of deliver	ry
sicia	in the past 12 months?  1  Yes 2 No  1  Yes 2 No  1  Yes 2 No  1  Yes 2 No			Month	Day Year
۵.	9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	220 814	tabacco una	contribute to th	e cause of death?
ed by	given the control of				ably 4 @Unknown
ompieted		24a. Was	an 2	4b. Were autop	sy findings available
Com		— auto perfe 1 ☐ Yes	prmed? 2 No	prior to con death? 1 \(\sum \) Yes	npletion of cause of 2 No
Be	examiner?	f Death (Check only	one)		
. To	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursi  27. Manner of Death 28a. Date of Injury. 28b. Time of 28c. Injury at	ing Home 5 PRes 28d. Describe			)
tion	1		now injury oc	2001190	
Certification;	3   Suicide 6   Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location ( City or To	Street and N wn, State)	umber or Rural	Route Number,
	29a. Certifier  (Check only (Check only 2) Medical Examinar: On the basis of examination and/or investigation in my oninion death	place, and due to the	cause(s) and	d manner as sta	ated.
Aedicai	one) and manner stated.	occurred at the time,			
Σ	29b. Signature and title of certifier  29c. License number	,	. /	igned (Month, E	Day, Year)
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		11/1:	7/05	
1	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Telegraph. Remarking Johns Harking University,  31. Date filed (Month, Day, Year)  NOV 2 1 2005	Baltmare	MN		
	31. Date filed (Month, Day, Year) 32. Registrar's Signature				

				State of N						All Copies Mental Hyg		egible.	
			1 - For State Registrar		,				Death		eg. No.	005	37508
	Physic		Decedent's Name (First, Middle, La     John Adolph Mansperge	,						2. Date of Dea Month	th Day	Year 05	3. Time of Death
	/Medi Exami		4a. Facility Name (If not institution, give	e street and numbe	r)		4b. City	, Town, o	Location of Dea	ith		unty of Deat	
	*. 		Franklin Square			nter.	K	0500	lak		Bo	2 1hm	ore-
	Funeral Director		5. Social Security Number 6. 5 212-34-1508	Sex 7. A	kge (In yrs. 1	last birthday) Yrs.	If Unde Months	Days	If Under 24 Hr Hours Mir		Year) 1936	9. Birt	hplace (State or Foreign ountry) ~yland
	pur *		Usual Residence of Decedent  10a. State 10b. County		10c Cit	y, Town or Lo	cation						
	ith the Marylar or 28a-f show	Director	MD Baltimor	e		Baltimor							10d. Inside City Limits
	with the ser 2.	Dire	10e. Street and Number	100110			10f. Zi	p Code	_	1	-	of What Co	untry?
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John 1 5-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "neturel; or iteme 23s or 28s-f show other traumatic event, the Medical Examt are must be notified at	Š	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces  1 Yes 2 1  If Yes, Give  Year or Dates	? [No	1	Yes, spe	ecify Cuba	in, Mexican, Pue	rto Rican, etc.)		Black, White ecity: Wh	e, etc.
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ي الم	d tal Hy	Be	17. Father's Name (First, Middle, Last John A. Mansperger							me (First, Middle, I	Maiden Sui	mame)	
Perger	should be nd Mental marked c	2				T				Pinkerton			
5 2	d 2 si th and 7 is r		19a. Informant's Name/Relationship ( Mary Jane Mansperge			1				Rural Route Number		own, State, 2	(ip Code)
	s 1 and f Health Item 27 other tr		20a. Method of Disposition	-1	20b. P	lace of Dispo-	sition (Na	me of		verlea, MD		on - City or	Town, State
200	Pages nent of h int: if its	18	1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Control C		в	emetery, cren avlaupod	•	-	1	10 2005	19	-744	140
Mans	permit. Pages 1 and 2 should be filed within Depertment of Health and Mental Hygiene. Important: if Item 27 is marked other type injury or other fraumatic event, the Magnee.		21. Signature of Funeral Service Lice		1		Name a	nd Addres	ss of Facility Le	18, 2005 conard J. Ru	ck Inc	altiror	e, m
-			23a. Part1. Enter the disease, or com	plications that cause	ed the death	Do not ente	305 H	arford	d Rd. Balt	imore, MD 2	1214		Approximate
	Dhysisian		shock, or heart failure. List only Immediate Cause (Final	one cause on each	iine.	0				ic or respiratory arri	331,		Interval Between Onset and Death
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P.O. Box 68760.	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  In the Funerel Districtor: After this certificate hes been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	by Physician/Medic	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcom 1 Live birth 4 Pregnant 9 Unknown	2 Fetal	death 3	Ectopic p Other (s <sub>t</sub>	regnancy pecify)			23d.	Date of deli Month	very Day Year
۵.	s that	y PI	Part II. Other significant conditions of	ontributing to death	but not resu	ılting in the un	derlying o	cause give	en in Part I.	23e. Did tob	acco use c	contribute to	the cause of death?
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S	law re es be 2 sho	Completed								24a. Was a		b. Were au	topsy findings available
<u> </u>	The ete h	E O								autops perform 1 X Yes 2	ned?	death?	ompletion of cause of 2 \( \subseteq \text{No} \)
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o Jo	Physical direction	<b>T</b>	1 ☐ Yes 2 🕏 No  27. Manner of Death	Hospital: 1 Anpat		ER/Outpatient			4   Nursing i	Home 5 Reside			uty)
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Division of Vital Records.	l or Attendi after death. Director: A in by the fu	Certification;	2 Accident investigation 3 Suicide 6 Could not b 4 Homicide determined	28e. Place of In	njury - At ho etc. (Specify	me, farm, stre				28f. Location (Str City or Town	eet and Nu , State)	ımber or Ru	ral Route Number,
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	To th To th comp	Me	29b. Signature and title of certifier	1			290	c. License	number	29	d. Date sig	ned (Month	, Day, Year)
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107			30. Name and address of person who	completed cause of	death (Item	23a) (Type, F	Print)	000	Dollar	Bu Hinn	se A	41 2	1237
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p.*		ec.	Registrar  1. Decedent's Name (First, Middle, Last,		Cei	rtificate of	Deam	2. Date of Deatl	g. 2005	3/303
	Physici	an	THAN	AVA				Month	Day Year	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, give	street and number)		4b. City. Town.	or Location of Deat	1	1( 2005)	
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74 5 26 5	Funeral		5. Social Security Number 6. Sec	7. Age	(In yrs. last birthday)	If Under 1 Year Months Days		8. Date of Birth (Month, Day,	9. Bir	thplace (State or Foreign
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	and *		Usual Residence of Decedent  10a, State 10b, County		10c. City, Town or Lo	cation				10d. Inside City Limits
	daryis f sho	ō			Silver					1 ☐ Yes 2 √ No
	28a-	Director	MD Montgome  10e. Street and Number	Ly	SIIVEI	10f. Zip Code		10	og. Citizen of What Co	77
	3a or		1400 Fenwick Lane	#111			20906		USA	,
	deatl	by Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U.S. 13.	Was Decedent of	Hispanic Origin? (S oan, Mexican, Puer	pecify Yes or No-	14. Race - Ame	
9	or Ite	II.	1 Never Married 2 Married	1 ☐ Yes 2 No		1 ☐ Yes 2 X No		o nican, etc.)	Specify:	asian
Maryland 21215-0036	within 72 hours after death with the Maryland ene. than "naturel", or Iteme 23a or 28a-f show the Medical Executar transl be notified at		3 ₩ Widowed 4 Divorced	Year or Dates:						
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ary	and h		19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Maili	ng Address (Stree	t and Number or Ru	ıral Route Number,	City or Town, State, .	Zip Code)
	and and no no no no tr		Thida Saw/daughter	2	With the second		A A STATE OF THE REAL PROPERTY AND ADDRESS OF THE PARTY AND ADDRESS OF	Gaithers	burg, MD	20879
ore	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Marylan Deperment of Health and Menial Hygiene. Important: If item 27 is marked other than "naturat", or iteme 23a or 28a-f show any injury or other traumatic event, If a Medical Exaction or market colling and once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F	lemoval from State	20b. Place of Dispo cemetery, crei	osition (Name of matory or other pla	ace)	Date 2	loc. Location - City or	Town, State
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Baltimore,	Depermit Deper Impor any In		21. Signature of Funeral Service Licens Ronald	Jade Divy	etot Si	2. Name and Addr tate Anat			Baltimore	Street
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			shock, ir heart failure. List only of timediate C use (Final	ne cause on each line					51,	Interval Between Onset and Death
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<u>~</u>	Physiclan: The la ir this certificate hes aral director, page 2	2	1 □ Yes 2 No	lospitat: 1 🗶 Inpatient	2 ER/Outpatier	nt 3 DOA Ot	her: 4 🗆 Nursing H	ome 5 Resider	nce 6 Other (Spe	city)
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Division of Vital Records,	I or Attendi after death. Director: A I in by the fu	Certification;	4 Homicide determined	building, etc.	y - At home, farm, str (Specify)	eet, factory, office		City or Town,	eet and Number or Ru State)	urai Route Number,
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pc.			SUNIA HOLMES, M		PRINCE PH	IUIL DEN	M, UINE	Y, MD Z	0832-	
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		State of Maryland / Department of Health and Mental Hygiene  1 - State State Certificate of Death Reg. No. 200	5 37510
· Phys	sician	1. Decedent's Name (First, Middle, Last)  2. Date of Death Month Day Yea	
/Me	edical miner	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of De	03 1
- Funer		2.10 11 10 TO ST NOM 2 F Yes Months Days Hours Min. Month, Day, Year)	lirthplace (State or Foreign Country)
faryland show	J.	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits 1 □ Yes 2 □ No
death with the Maryland me 23a or 28e-f show	Director	10e. Street and Number  10f. Zip Code  10g. Citizen of What	/ /
	Funerai	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Mar	nerican Indian, nite, etc.
5-UU36 72 hours after 'naturel', or ite	eted by	3 ☐ Widowed 4 Divorced   If Yes, Give / Year or Dates:   1 ☐ Yes 2 ☑ No Specify:   Spec	S/Industry
C Z I Z I ; filed within 7 Hygiene. other then "r	Completed		facturer
		James Mesbitt Annie Alsta	7
re, Marylis s 1 end 2 should f Health and Mer item 27 ie marke		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State  Le Stwart-dougtler 3300 Aurora Lane Art Bacto, md.  20a. Method of Disposition  20b. Place of Disposition (Name of Date 20c. Location - City	21207
O ≋≗≥ 5		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  1/28/05  WW (aux	0
permit. Par Department Importent:	once.	21. Signature of Funeral Service Licenses 22. Name and Address of Facility Pass  Cary P. March Riveral Home Beetle.	nd, 21229
Pnysicia	an	23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition	Approximate Interval Between Onset and Death
/Medic Examin		Due to (or a la consequence of):	Ü
ecuted and transit	Examiner		
Certificate be executed ding physicien and use as the burial-transit	Ca	d	
Geath death death death death	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	lelivery Day Year
ecords, P.C. law requires that the de as been signed by the a			to the cause of death?
The Tee	d Wo	24a. Was an 24b. Were autopsy performed? death	autopsy findings available o completion of cause of ?
OT VITAL Physician: 1 rthis certifical ral director, p	To Be C	25. Was case referred to medical examiner? 26. Place of Death (Check only one)	
VISION OT VITA Attending Physician: or death. ector: After this certific. by the funeral director,	atlon: T	27. Manger of Death  1 Natural 5 Pending 2 Accident investigation  28a. Date of Injury (Month, Day Year)  28b. Time of Injury Work?  1 Yes 2 No  28d. Describe how injury occurred Work?	isunyj
DIVISION Ital or Attending Ital or Attending Its effer death.  Tal Director: After led in by the function	Certification:		
DIVISION  To the Hospital or Attending I within 24 hours effer death. To the Funeral Director: Affer completely filled in by the funer	Medical	00-1:	ue to the cause(s)
or with	3	James Janohne 033061 November	105 (9, 2005)
	65	30 Name and address of person who completed cause of death (Item 23a) (Type, Print)  Stages to person who completed cause of death (Item 23a) (Type, Print)  Stages to person who completed cause of death (Item 23a) (Type, Print)	Soundes
Reg	State Jistrar	31. Date filed (Nonth, Day, Year) 32. Registrar's Signature	

			1 - For State Registrar	State of Maryland /	Department of Health a Certificate of Death	and Mental Hy	rgieme 005 37511
	Physici	an	1. Decedent's Name (First, Middle, Last, James R.			2. Date of De Month	Day Year 2 57 4.
	/Medic Examin Funeral Director		4a. Facility Name (If not institution, give Baltmore V.  5. Social Security Number 6. Se	A Medical G	enter Baltimo	re	
	e-f show	ctor	Usual Residence of Decedent  10a. State 10b. County	A 10c. City, Too	wn or Location Balliman	0	10d. Inside City Limits 1 ⊠Yes 2 □ No
	th with the 23e or 28 ist be no	Funeral Director	10e. Street and Number 542 G An I	Hop Are	10f. Zip Code 2/2	06	10g. Citizen of What Country?
5-0036	72 hours atter death with the Maryland natural', or itema 23e or 28e-f show diest Examiner must be notified at		11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No 1Yes, Give Year or Dates:	13. Was Decedent of Hispanic Ori If Yes, specify Cuban, Mexican 1 Yes 2 No Specify:	n, Puerto Rican, etc.)	o- 14. Race - American Indian, Black, White, etc.  Specify:
21215-0	C * 3	Completed by	15. Decedent's Ed. (Specify only highest grad Elementary/Secondary (0-12)	cation (e completed)  College (1-4or 5+)	a. Decedent's Usual Occupation (Give kind of work done during mos life, DO NOT use retired)	it of working	Bothlehem Hel
Maryland	should be filed within and Mental Hygiene.  s marked other than umatic evant, Ine M	To Be C	17. Father's Name (First, Middle, Last)	Le		er's Name (First, Middle	unknown
_	1 and 2 s fealth ar om 27 is thar trau		19a. Informant's Name/Relationship (T)  May Patterson  20a. Method of Disposition	-daughter 3	b. Mailing Address (Street and Number)  (19   AR  of Disposition (Name of	er or Rural Route Numb  Date	ner, City or Town, State, Zip Code)  Mdi 2 i 2 i 3  20c. Location - City or Town, State
altimore,	t. Page tment o tant: If jury or		1 Burial 2 □ Cremation 3 □ F  '4 □ Donation 5 □ Other (Specify)  21. Sign	Removal from State	ery, crematory or other place)	1/28/05	owings nices, nd.
Ba	Depar Impor any ir		Janey M,	laclace	22. Name and Address of Facility  The substitution of the substitu	lace true	
	Pnysician /Medical Examiner		23a. Partl. Enter the disease, or compishors, or heaft failure. List only of Immediate Cause (Final disease or condition resulting in death)	ilications that ceused the death. Do no cause on each line.  a			Onset and Death
8760,	cate be executed oblysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence  Due to (or as a consequence  d.	9 of):		
P.O. Box 68	The law requires that the death certifical ate has been signed by the attending phroage 2 should be detached for use as the	Completed by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal deat 4 □ Pregnant at time of death 9 □ Unknown	th 3 Ectopic pregnancy 5 Other (specify)		23d. Date of delivery Month Day Year
	w requires that been signed b should be deta	ed by PI	Part II. Other significant conditions co	ntributing to death but not resulting	in the underlying cause given in Part I		tobacco use contribute to the cause of death?  Yes 2 \( \text{No} \) 3 \( \text{Probably} \) 4 \( \text{Unknown} \)
Il Records,		Complet				24a. Was auto perfo 1 🗆 Yes	
Vital	Physiclan: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	Other	of Death (Check only	
of	nding Physith. :: After this e tuneral di	ation: To	27. Manner of Death    Natural   5   Pending     2   Accident   investigation		Dutpatient 3 □ DOA 28c. Injury at Work?  M 1 □ Yes 2 □	28d. Describe	idence 6 Other (Specify) how injury occurred
Division	To the Hospital or Attending within 24 hours effer death.  To the Funeral Diractor: After completely tilled in by the tune.	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury · At home, to building, etc. (Specify)	arm, street, factory, office		Street and Number or Rural Route Number, wm. State)
	To the Hospital or At within 24 hours effer d To the Funeral Diract completely tilled in by	Medical			ge, death occurred at the time, date an ind/or investigation, in my opinion, dea		cause(s) and manner as stated. date and place, and due to the cause(s)
	To the To the Comple	Me	29b. Signature and title of certifier		29c. License number		29d. Date signed (Month, Day, Year)
\ \ \	N		1690	> M.D.	P17643	3	NOV 18, 2005
1	1		30. Name and address of person who of WEN-YEE TSA1			ORE MO	21201
ı	Sta Registi		31. Date filed (Month, Day, Year) NOV 2 1 20	32 (Registrar's Signature	REENE S! BALTIH	1	- 16 01

DARREN PARKER 05-07720 RJ

77	20	4	State	ate of Ma	aryland		artment of H		Mental H	/	41111	)5	37512
			Registrar  1. Decedent's Name (First, Middle, Last)				tillcate of t	Jean	2. Date of D	Reg. Att	j		3. Time of Death
	Physicia		_	D			Park	or	Novem	Da		Year	11:17 p.
198	/Medic		Darren  4a. Facility Name (If not institution, give street		•		4b. City, Town, or				c. County	2005 of Death	11:1/ p.
* 33	Examin	er	University Hospital		Trau	ma		imore					
	Funeral		5. Social Security Number 6. Sex		(In yrs. last		If Under 1 Year	If Under 24 H	rs. 8. Date of B	lirth		9. Birth	place (State or Foreign
30	Director		220-04-4207 1XM	2 🗆 F	21	Yrs.	Months Days	Hours Mi	n. (Month, L	31	84	Cou	MD
	P.		Usual Residence of Decedent		10c. City. T								10d. fnside City Limits
	aryla show	_	10a. State 10b. County										Y Yes 2 No
	Ba-f	octo	MD NA		ват	timo				10- 6	itizen of V	Albah Cau	
	with t	D.	10e. Street and Number		O 3	m1	10f. Zip Code	21217		log. C	U.S		iii y r
	eath 23	erai	539 Cumberland St	las Decedent 8	2nd		Was Decedent of H		(Specify Yes or N	10-			can Indian,
36	be filed within 72 hours after death with the Maryland hat Hygiene. od other then "naturel", or Iteme 23e or 28e-f show event, the Medical Examinat must be mailled at	by Funeral Director	1 Never Married 2 Marned 1	med Forces?  Yes 2 X Yes, Give ear or Dates:			If Yes, specify Cuba 1 ☐ Yes 2 🔀 No	in, Mexican, Pur Specify:	erto Rican, etc.)		Blac Specify	ck, White	etc. Black
9	hour		15. Decedent's Education		1	16a. Dece	dent's Usuaf Occup	ation		16b. h	Kind of Bu	usiness/Ir	ndustry
<u>T</u>	n na	Completed	(Specify only highest grade con	pleted)		(Give	kind of work done of DO NOT use retired	during most of w	vorking				,
212	y with	E o		ollege (1-4or5 1 <b>a</b>	(+)	Uı	nemploye	ed			Une	mpl	oyed
פַ	be filed ital Hygind other event,	Be C	17. Father's Name (First, Middle, Last)					18. Mother's N	lame (First, Midd	le, Maide	n Suman	ne)	
/lai	uld b Mentz rrked rtlc e	2	Frank Parker					Patri	.ca Won	son			
lan	2 should be filed withir and Mental Hygiene. Is marked other then aumatic event, the Ma		19a. Informant's Name/Relationship (Type, F				ng Address (Street						
≥,	and ealth m 27		Patrica Wonson-Mc	ther	Took Blan		Cumberl	and St		_			21217
Ore	ges 1 t of H if ite or oti		20a. Method of Disposition 1	val from State	cem	etery, cre	osition (Name of matory or other place		Date				own, State
Ē	Pa tmen tent:		4 □Donation 5 □Other (Specify)		Mt	. Z:			/22/05	Bal	Ltim	ore	, Md
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be Depertment of Health and Menta Important: If Item 27 Ie marked eny injury or other traumatic events.		21. Signature of Funeral Service License	Thor	mpan	~ M	2. Name and Address arch F/H 300 Waba	l West sh Ave	e, Balt	imor	ce,	Md	21215
9	di V		23a. Part1. Sheer the disease, or complication shock, or heart failure. List only one ca	ns that caused use on each lir	the death.	Do not en	ter the mode of dyin	ig, such as card	ac or respiratory	arrest,			Approximate interval Between
1	Physician		Immediate Cause (Final disease or condition	Multi	ple o	juns	hot wol	unus					Onset and Death
*	/Medical Examiner		resulting in death)	Due to (or as	a consequer	nce of):							
*	Examine	_	Sequentially list conditions, b	D 1- /			-						
	pe is	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequer	nce or):							
	wecut end II-trar	Examiner	that initiated events c resulting in death) Last	Due to (or as	a consequer	nce of):							
8760,	cate be executed physicien end the burial-transit	dical E											
687	ficate p phy:	edic	0	_									
Box	law requires that the death certificate be executed as been signed by the attending physicien end ? Should be detached for use as the burial-transit	Physician/Me		yes, outcome			75				23d. Da	ite of defin	rery
	death e atte	icia	in the past 12 months?	Live birth			∃Ectopic pregnancy ∃ Other (specify)	, 		-	Mo	onth	Day Year
P.O.	that the de ed by the detached	hys	9 Unknown	Unknown									
	res tha igned be del	by	Part fl. Other significant conditions contribu	ting to death b	ut not resulti	ng in the u	inderlying cause giv	en in Part I.					the cause of death?
ord	w require been si should	ted							- 1	]Yes 2	2 No	3 Pro	babiy 4 □Unknown
Division of Vital Records,	e taw r has be ge 2 sh	Completed							24a. Wa	topsy		prior to c	opsy findings available ompletion of cause of
<u>=</u>	Th ate pag	ပ္ပ							1 Yes	rformed? 2 ☐ N		death? Yes	2 🗆 No
/ita	ician: Th certificate rector, pag	Be	25. Was case referred to medicaf examiner?	tal			Oth		Death (Check only	y one)			
of	Physician: r this certific ral director,	၉	Yes 2 No Hospi 27. Manner of Death 28	1 tx inpatie		VOutpatie		4   Nursing	Home 5 Re		6 Oth		ify)
u	Jing After	tion	T I Traital at 5 I Torraing	Month, Da		fnjury	Wor	k? Yes 2 No	S.L.	104	sho	1	
İSİ	Attending r death. ector: After oy the fune	fica	3 Suicide 6 Could not be	Be. Place of fnj	ury - At hom	e, farm, si	reet, factory, office		28f. Location	(Street a	and Numl	ber or Rui	ral Route Number,
Ö	affer affer Dire	Certification:	4 Homicide determined	building, et	c. (Specify)	2 5	treet		street.	own, Sta	(+1 int	6/00	K Wilhelin
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edicai C	29a. Certifier (Check only one)  1 Certifying Physicie 2 Medical Examiner:	ก: To the best	of my knowle f examinatio	edge, dea	th occurred at the tir	me, date and pla pinion, death or	ace, and due to the	ne cause(	s) and ma	anner as	stated. to the cause(s)
	To the Mithin To the comple	Me	29b. Signature and title of certifier	2112111211101 011	2100.		29c. Licens			29d. D	ate signe	ed (Month	, Day, Year)
	r ≤ r ō		170/01/2	R A	50		OC	ME		Nov	embe	r 16	, 2005
	X		30. Name and address of person who comple	eted cause of c	Jeath (ftem 2	3a) (Type	Print) <b>111</b> D	enn Str	eet Rol	timo	re	Marri	land 21201
V	1		ZABILICEAH	AU			TIT L		cer Dal	CTIIO	16,	ricit y.	Land ZIZUI
	Sta	ate	31. Date fifed (Month, Day, Year)	32. gistr	ar's Signatu	re	Lank.						
1	Regist	rar	NOV 2 1 2005	Since	pie L	F. A.	borte						

			For State Registrar	State	of Marylan		rtment of He			giene Reg. No. 005	37513
	•		Decedent's Name (First, Middle, La.	,					2. Date of Dea		3. Time of Death
	Physicia /Medic				erine M.	Perzi				er 11, 200	05 11:01 A <sup>M</sup>
	Examin		4a. Fecility Name (If not institution, giv				4b. City, Town, or L			4c. County of D	
	Francis		Meridian Nursing 5. Social Security Number 6. S		ranklin 7. Age (In yrs.		Esse:	K If Under 24 Hrs.	8. Date of Birtl	h q	imore Co. Birthplace (State or Foreign
	Funeral Director			□M 2∏F	82	Yrs.	Months Days	Hours Min.	(Month, Day Sept.	v, Year)	Country) Michigan
	D .		Usuel Residence of Decedent  10a. State 10b. County		10c Cit	y, Town or Lo	action				10d. Inside City Limits
	shov	ក	Toa. State		100. 01	y, 10 mil 01 Lo	Action				1 ☐ Yes 2 ☑ No
,	286-f	recti	Maryland Bal  10e. Street and Number	timore		· · · · ·	10f. Zip Code	Nott	ingham	10g. Citizen of What	Country?
	3a or	0	3917 Putty Hill	Avenue	2			21236		United St	tates
	be lied within 72 nouts after death with the Maryland to Hygiene. d other than "natural", or items 23a or 28e-f show event, the Medical Evaninar must be inclined at	Funeral Director	11. Marital Status		edent Ever in U.	.S. 13. V	Vas Decedent of His Yes, specify Cuban	panic Origin? (Sp Mexican, Puerto	ecify Yes or No-	14. Race - A	American Indian, Vhite, etc.
9	or it	by Fu	1 Never Married 2 Married	1 ☐ Yes If Yes, G	2⊠No ive	-	☐ Yes 2K No	Specify:	, , , , , , , , , , , , , , , , , , , ,	Specify:	
3	turai'	ed b	3 ☐ Widowed 4 ☐ Divorced	Year or I	Dates:	16a, Deced	ent's Usual Occupat	ion		16b. Kind of Busine	White
<u>.</u>	Medic	Completed	(Specify only highest gra Elementary/Secondary (0-12)	ide completed,	) (1-4or 5+)	(Give	kind of work done du OO NOT use retired)	ring most of work	ring		,
7	giene er tha	E O	8 Years	Conlege		Bu	siness Own	ner		Taver	n
3	be file tal Hy d oth d oth	Be (	17. Father's Name (First, Middle, Last,				1			Maiden Sumame)	
7	a Men narke natic	၉	Gregory F. Roma  19a. Informant's Name/Relationship (			10b Mailia	- Address (Ctrost er		na Mush	LOCK or, City or Town, Stat	to Zin Codo)
2	d 2 st th and th sun traum		Mr. Harry Perzins		sband)		Putty Hi			ore, Mary	
บ์	s 1 an f Heal f Heal item 2 other		20a. Method of Disposition		20b. P		sition (Name of natory or other place,		Date	20c. Location - City	or Town, State
2	Page:		¹XXBurial 2 ☐ Cremation 3 ☐  `4 ☐ Donation 5 ☐ Other (Specif		State		Cemetery	11/15/	2005	Baltimo	re, Maryland
Dallinor	permit. Pages 1 and 2 should be lited within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. By the man 21 is marked other than "natural", or items 23a or 28e-1 show any injury or other traumatic event, the Medical Examinat must be inclined at once.		21. Signature of Funeral Service Lice	1600	-	D	Name and Address	Funeral	Home of	Dundalk,	Inc. 21222
3			23a. Part1. Enter the disease, or com	plications that	caused the deat		922 Wise A er the mode of dying,				Approximate Interval Between
F	hysician .		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. A:	SPIRA		PNE	EUMON	(A		Onset and Death
	/Medical Examiner		resulting in dealth)	Due to	Of as a conseq	uence of):	- ENS		TAGE		
		Jer	Sequentially list conditions, if any, leading to immediate	b	(or as a conseq			-	, ( )   C   G		
	cuted nd ransit	Examine	If any, leading to introduct cause. Enter Underlying Cause (Disease or injury that initiated events	c							
,00	The law requires that the death certificate be executed itse has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	EX	resulting in death) Last	Due to	o (or as a conseq	uence of):					
0	physical phy	dlcal		_ d							
X	w requires that the death certific been signed by the attending p should be detached for use as	hysiclan/Me	IF FEMALE: 23b. Was decedent pregnant		utcome of pregna		1=			23d. Date of	delivery
Ď	death ne atte	sicla	in the past 12 months? 1 ☐ Yes 2 ☐ No		birth 2 ☐ Feta gnant at time of d		Ectopic pregnancy Other (specify)			Month	Day Year
Э	d by the	Phy	9 Unknown			ulkina in the		in Doet I	220 Did to	hagan uso contribut	e to the cause of death?
, S	signer signer d be d	by	Part II. Other significant conditions of LUPU	-		-		in Pani.			Probably 4 Unknown
ecoras,	v requ been shoule	etec							24a. Was		autopsy findings available
i e	The lav	ompleted							autop perfor	sy prior med? deat	to completion of cause of
	sician: The lav certificate has rector, page 2	O	25. Was case referred to medical					26. Place of Dea	1 ☐ Yes	2 No 1 1 \(\frac{1}{2}\)	Yes 2 No
<u> </u>	lysician: ils certific director,	To B	examiner? 1 ☐ Yes 🗽 No	Hospital: 1	Inpatient 2	ER/Outpatien	Other	1777		lence 6 Other (5	Specify)
o uo	spitei or Attending Physions after death. eral Director: After this filled in by the funeral di	Ë	27. Manner of Death  1 Natural 5 Pending investigation		e of Injury onth, Day Year)	28b. Time of Injury	Work?	at es 2 □ No	28d. Describe h	low injury occurred	
DIVISION	Atten or deat ector: by the	Certificatio	2 Accident investigation 3 Suicide 6 Could not be determined	e 28e. Plac	ce of Injury - At h	ome, farm, str	eet, factory, office		28f. Location (S City or Tow		r Rural Route Number,
5	Itei or irs afte ral Dir led in	Cert	Tomodo	Duin	uling, etc. (Specin			p	Ony or 1011		
	To the Hospitel or Attending Physicien: state 24 hours after death as a few death To the Funeral Director: After this certifica completely filled in by the funeral director.	Medical		miner: On the						cause(s) and manne date and place, and	
	To the within To the comp	Ň	29b. Signature and title of certifier	/ /			29c. License			29d. Date signed (M	onth, Day, Year)
			fin tar	shal	2		D40	100 8	3	11 /11	05
7			30. Name and address of person who		use of death (Item 910.5	п 23a) (Туре,	Print)	DUNCE	DR G	3017	E MO 2122
1	Sta	ate	31. Date filed (Month, Day, Year)	HALL 32.	Desistrado Cisso	ature	1 L = 11 2	O UHEE	UN., E	MEIIMON	E MD. 21237
	Registi		NOV 2 1	2005	Weller a	# 4	Carle				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Month JUNIOR RICE 12:50 November 17 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Sinai Baltimore Baltimore C If Under 1 Year | If Under 24 Hrs. NA Hospital 0 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**8**M 2□F Days Months Hours Min 72 Yrs. 250.48.1538 Director Usual Residence of Decedent 10c. City, Town or Location 10b County 10a State 10d. Inside City Limits show other traumatic avant, the Medical Examiner must be notified at NIA MD 1 XYes 2 No Director BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21223 1700 EDMONDSON AVENUE USA items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 250 Married ō land 21215-0036 1 Yes 2 No Specify: þ Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Is marked othar than Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. GRADE LABORER SPICE COMPANY 8/H NA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) DOCK RICE FLOSSIE LANCE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or othar trau once. SON 3312 W. GARRISON AVE. BALTIMORE CHRISTOPHER RICE MD Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Surial 2 ☐ Cremation 3 ☐ Removal from State KING PARK <sup>¹</sup> 4 □ Donation 5 □ Other (Specify) 11.21.05 RANDALISTOWN, MO VAUGHN C. GREENE FUNERAL SERVICE 5151 BAGO, NATU FIRE BAITO, MD 21229 21. Signature of Funeral Service Licens anghin 23a. Part 1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical esn IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No ō Day 4 Pregnant at time of death 5 Other (specify) the 9 Unknown þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Hyper lipicemia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No page 2 s certificate 25. Was case referred to medical director 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 No 2 1 🗌 Yes this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending 1 ☐ Yes 2 ☐ No investigation s after death 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide within 24 hours a 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number RFS-000 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature Sinai Hospital 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Sand ens **Physician** Esterleen November 16, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Edgecombe ConteNorth Baltmone 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 6. Sex 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) 1 M 202 F Months Days Hours 217-34-668 Director June 17, 1934 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits or 28a-f show other treumatic event, the Mudical Examinar must be notified at 1 DVes 2 □ No Baltymone Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA ecombe CinckNorth 21215 or items 23a 680 by Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 █ No Baltimore, Maryland 21215-0036 Specify Black Specify: 3 Widowed 4 □ Divorced "netural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) s and Mental Hygiene. College (1-4or 5+) Domestoe 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be BLICK Wilhelmia ٩ Dallas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip permit. Pages 1 and 2 Department of Heelth a Importent: If Item 27 is any Injury or other tret once. Balk ME ZIZIS 2837 Edg concle North Saunders/daughter e combe Danita 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place 1 WBurial 2 Cremation 3 Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) 105 Foreral Service P-14. 21. Signature of Furieral Service Li lose SIZE BELOWN Road Bactons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, it only one cause on each line. Road Baltmore Mi 23a. Part1. Enter the disease, or comshock, or heart failure. List only Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Month sequential, list or drions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit the attending physician and Due to (or as a consequence Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown ate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐Unknown 1 🗌 Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 210 No 1 ☐ Yes 2 No 1 Yes Hospitel or Attending Physicien: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: filled in by the 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funerel Direct 4 - Homicide dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

In the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0059014 11118105 30. Name and address of pe o omplete cause of death (Item 23a) (Type, Print) PARK 100 W 32 Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

2005

**ORIGINAL** 

		•	For State Registrar	State of Ma		partment of ertificate of		nd Mental Hyg	iene2	005	37517
7	Physici		Decedent's Name (First, Middle, Last, Lucille		mma	S	mith	2. Date of Deat Month	Day	2005	3. Time of Death
2 1	/Medic Examir		4a. Facility Name (If not institution, give ST Agnes			4b. City, Town,	CAT		_	unty of Death	77.20
**	Funeral Director		5. Social Security Number 6. Sec 214-24-7122 Usual Residence of Decedent	7. Ag	78 Yrs.	y) If Under 1 Yea Months Day		4 Hrs. 8. Date of Birth (Month, Day, 04 12	Year) 27	Cou	place (State or Foreign intry) MD
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	or 288	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen	of What Cou	intry?
	leath v		3931 West Mulber	cry Stre			229 Hispanic Origi	n? (Specify Yes or No-		U.S.A Race - Ameri	
980	ours after o al', or iten	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1 Yes 201  If Yes, Give Year or Dates:		If Yes, specify Cu 1 ☐ Yes 2 🔀 N		n? (Specify Yes or No- Puerto Rican, etc.)		Black, White	
Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Marylan It of Health and Mental Hygiene. If Item 27 is marked other then "netural", or items 23s or 28s-f show or other traumatic event, the Madical Examinar must be notified at	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		(Gin life	edent's Usual Occ le kind of work don DO NOT use retin	e during most o ed)	of working		of Business/Ir	
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rylan	should be and Mental I marked o umatic eve	To Be	Vester Smith	Seizel			Mabe:	l Harris			
ā N	th and the and		19a. Informant's Name/Relationship (Ty	_	12221			or Rural Route Number			,
	of Health of Health item 27 i		Emanuel Smith—Gi 20a. Method of Disposition		20b. Place of Dis	Desition (Name of rematory or other p		ry St., B		more, ion - City or T	
<u><u>E</u></u>	Pages ment of I ent: If It		1 □XBurial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	Removal from State	1		1	11/19/05	Rand	allst	own, Md
Baltimore,	permit. Pages Department of Importent: If I any njury or one.		21. Signature of Funeral Service Licens	B.Ke		22. Name and Add	H Wes				21215
a de la composition della comp	Physician		23a. Part 1 Enter the disease, or compleshock or heart failure. List only of immediate Cause (Final disease or condition	ne cause on each II	the death. Do not e	inter the mode of d	ring, such as ca	ardiac or respiratory arre	est,		Approximate Interval Between Onset and Death
    e	/Medical Examiner		resulting in death)  Sequentially list conditions.	Due to (or as	a consequence of):	adovi	cula	disease			10 year
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rds, P	w requires that been signed b should be deta	ed by Pr	Pan II. Other significant conditions co.				pven in Part I.		oacco use es 2□N		the cause of death?
Division of Vital Records,	The law requate has been page 2 should	Completed by						24a. Was a autops perform	ned?_	prior to co death?	opsy findings available ompletion of cause of
/ita	cian: ertifica ector,	Be	25. Was case referred to medical examiner?					of Death  Check only on	θ)		
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sion	To the Hospitel or Attending Physician: The law within 24 hours effer death. To the Funerel Director: Affer this certificate has completely filled in by the funeral director, page 2	Certification:	1	28a. Date of Inju (Month, Da		M 1	]Yes 2 □No				
<u>≥</u>	itel or A	Certif	4 Homicide determined	building, et	ury - At home, farm, c. (Specify)			28f. Location (St City or Town	n, State)		
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	with To I	Σ	29b. Signature and title of certifier				nse number			gned (Month,	
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Ä	1		30. Name and address of person who con St Agne thorpitel. Si						-212		
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AA	Physici	_	Viola W. Salmor	•				Novemb	Day	Year 2:20 AM
	/Medio Examin		4a. Facility Name (If not institution, gir	ve street and number)	000	4b. City, Town, or	Location of Dear	h	4c. County of	
ph.	Funeral		5. Social Security Number 6.	Sex 7. Age (In	yrs. last birthday)	If Under 1 Year	If Under 24 Hrs	8. Date of Bir	th	9. Birthplace (State or Foreign
46	Director		145-18-2836	1□M 25√F	82 Yrs.	Months Days	Hours Min	May 31	ay, Year)	Country) New Jersey
	Pt.		Usual Residence of Decedent					1100) 523		
	arylar ehow	_	10a. State 10b. County	100	c. City, Town or Lo					10d. Inside City Limits
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	with t	늅	10e. Street and Number 29262 Corbin Pan	ckway		10f. Zip Code	2160	1	10g. Citizen of Wh	•
	leath	Funeral	11. Marital Status	12. Was Decedent Ever	in U.S.   13.1	Was Decedent of Hi				- American Indian.
0	r Itan	표	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 📆 No		Nas Decedent of Hi f Yes, specify Cuba	n, Mexican, Puer	to Rican, etc.)		White, etc.
036	alf, o	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2∏ No	Specify:		Specify:	white
5-0	natui	Completed	15. Decedent's 8 (Specify only highest gi	Education rade completed)	16a. Deced	dent's Usual Occupa	ation furing most of wa	rkina	16b. Kind of Busi	iness/Industry
2	han ne.	du	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done o OO NOT use retired		9		
2	lied y lygie ther t		17. Father's Name (First, Middle, Las	0	bookk	eeper/sec		ma /Fimt Middle	consti	ruction
Maryland 21215-0036	and be formulated of the control of	) Be	Jacob Weislogel	.,				la Viola		)
Z	should nd Me mark matic	2	19a. Informant's Name/Relationship	(Type, Print)	19b. Mailir	ng Address (Street a			er, City or Town, S	tate Zin Codel
<b>≥</b>	od 2 s lith ar 27 le r trau		Gilbert Salmond						MD 21601	
ā,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 ie marked other than "natural", or itame 23e or 28e-f ehow expiritury or other traumatic event, the Medical Examinating the motified at once.		20a. Method of Disposition	20	Ob. Place of Dispo	sition (Name of natory or other place	alkway I	Date		ity or Town, State
ũ	Pages ent of nt: If i		1 ☐ Burial 2 ☐ Cremation 3 [ 4 ☑ Donation 5 ☐ Other (Spec	THEILIONAL HOW STATE	cemetery, cres	natory or other place	θ)			
altimore,	mit. I partm sorta / Inju		21. Si nature a Funeral Service Uce Ronald S		22	. Name and Addres	s of Facility	1 (55 11	D 1. *	re Street
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			23a. Part1. Enter the disease, or con shock, or heart failure. List only	nolications that caused the	death. Do not ent	er the mode of dying	g, such as cardia	c or respiratory a	rrest,	Approximate Interval Between
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	anding use	N.	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pr		35			23d. Date	of delivery
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o.	at the by th	hys	9 Unknown	9□ Unknown						
	es tha	by F	Part II. Other significant conditions	contributing to death but no	t resulting in the u	nderlying cause give	en in Part I.	23e. Did t	obacco use contrib	oute to the cause of death?
Spi	w requir been si should	ted				·		1 🗆 '	Yes 2 No 3	Probably 4 Unknown
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ģ	al or A after I Direct d in by	Certification:	4 ☐ Homicide determined	building, etc. (S)	pecify)	ori, ractory, omoc		City or To	wn, State)	or rigid rigid right
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate the completely filled in by the funeral director, page		29a Certifier 1X Certifying P	hysician: To the best of my	/ knowledge death	secured at the tin	a date and place	and due to the	sausė(s) and man	nor de stated.
	the H in 24 the Fi	Medical	(Check only 2 Medical Exa	miner: On the basis of exa and manner stated.	mination and/or in	estigation, in my or	pinion, death occi	urred at the time,	date and place, an	d due to the cause(s)
	Veith To 1	Σ	29b. Signature and title of certifier			29c. License			29d. Date signed (	(Month, Day, Year)
			Musturen h	Cartin M.	0	RE	5-000		November	,16,2005
			30. Name and address of person who				n A .			
100			Nastaran Rafi			pital of	Bult	·more		
	Sta Regista	THE REAL PROPERTY.	31. Date filed (Month, Day, Year) NOV 2 1	2005 32 agistrar's s	Signature	September 1				

	. *	1 - State Registrar Amend Item # 1. Pecedent's Name (First, Middle, Last)	State of Maryland  9 Per FH G849	11 <i>Pz</i> r	rtment of F	lealth and Death	2. Date of De	Reg. No.	005	375   9
Physic /Medi Exami	cal	4a. Facility Name (If not institution, give s	street and number)		SAW 4b. City, Town, o	r Location of Dea	Novem			
Funeral		5. Social Security Number 6. Sex	Opkins 140 7. Age (In yrs. Ia 7		If Under 1 Year Months Days	Li mo If Under 24 Hr Hours Mir		/ (v. Year) 193	9. Bir	rthplace (State or Foreign
Director would	J.	Usual Residence of Decedent   10a. State   10b. County   MD	10c. City,	Town or Loc	eation		Aug 19,	193	94 mary	10d. Inside City Limits 1 X es 2 □ No
with the M ta or 28e-f	Funeral Director	10e. Street and Number 2540 W. Lafayette	no.	THOTE	10f. Zip Code 21216			-	zen of What C	country?
be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or itema 23a or 28e-f ehow event, the Madreal Exercitor must be notified.	by		12. Was Decedent Ever in U.S Armed Forces? 1Yes _2 _XNo If Yes, Give Year or Dates:	If	/as Decedent of Nas Decedent of Nas Specify Cub	dispanic Origin? ( an, Mexican, Pue Specify:	Specify Yes or No irto Rican, etc.)		14. Race - Am Black, Whi	
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nd 2 shuith and 27 is m		19a. Informant's Name/Relationship (Ty, Everlon Moulton /D	aughter	4852 I	ławksbur	and Number or F y Road P	Rural Route Numberikesville	e, MI	21208	3
0 0		20a. Method of Disposition 1	emoval from State Arb	metery, crem utus M	ition (Name of atory or other pla [emorial	Park		Balt	imore,	
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ificate be executed g physicien and as the burial-transit	icai	L	1.	3100 OI).						
The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnapt in the past 12 moor s? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnan 1 ☐ Live birth 2 ☐ Fetal ( 4 ☐ Pregnant at time of dea 9 ☐ Unknown	death 3⊡	Ectopic pregnanc Other (specify) _	/		2	3d. Date of de Month	olivery Day Year
quires that en signed b suld be deta	þ	Part II. Other significant conditions cor	ntributing to death but not resul	ting in the un	derlying cause gr	ren in Part I.	23e. Did to			o the cause of death?
: The law requ cate has been page 2 shout	Completed								prior to death?	utopsy findings available completion of cause of
ysicien: The sectificate director, pag	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	lospital:	:R/Outpatient	3□ DOA Ott		eath <i>Check only</i> of Home 5 Resid		Other /Sne	acifu)
tending Ph eath. for: After th the funeral	Certification; T	27. Mann of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be		28b. Time of Injury	M 28c Inju Wo M 1		28d. Describe I	now injury	occurred .	tural Route Number.
i Diffic		4 Homicide determined  29a. Certifier 1 Vertifying Physics	building, etc. (Specify)	rledge, death	occurred at the ti	me, date and place	City or Tov	vn, State)	and manner a	s stated
To the Hospitel within 24 hours to To the Funerel completely filled	Medical	(Check only 2 Medical Examile one)  29b. Signature and title of certifies	ner: On the basis of examination and manner stated.	on and/or inv	estigation, in my o	e number	curred at the time,	date and	place, and du	e to the cause(s)
<b>5</b>		30. Name and a dress of person who con STEPHEN M. CATAM.  31. Date filed (Month, Day, Year)	mpleted cause of death (Item)	23a) (Type, F	Print)	S-000		Nov	EMBER	12, 2005
		STEPHEN M. CATTAN 31. Date filed (Month, Day, Year)	EO M.D. 600 3 Registrar's Signature	NW	OUFE ST	ELET, B	ALTMORE	E M	ARYLA	WD 21287

			For				rtment of H		Mental Hy	giene		
			= Stata Registrar Amend Ite	n #1 Per	ME G849	11921	tificatemof l	Death		Rag. No	005	37520
	Physicia		Decedent's Name (First, Middle,	Last)	astine				2. Date of Dea Month Novembe	Dav	2005	0424 M
	/Medic Examin	0	4a. Facility Name (If not institution,		mber)			Location of Death	1	4c. (	County of Dea	th
3			Johns Hopkins 5. Social Security Number	Hospital .Sex	7. Age (In yrs.	(a a t b oth da)	Baltimo		8. Date of Birt	b	N/A	thplace (State or Foreign
	Funeral Director		215-22-3592	1 M 2 ₩ F	7. Age (117 yrs.	Yrs.	Months Days	Hours Min.	Jan. 15	y, Year)	Co	ntucky
	D		Usual Residence of Decedent  10a, State 10b, County		100 Cit	y, Town or Lo	action					10d. Inside City Limits
	ith the Marylar or 28a-f show	ō	Maryland Maryland	N/A	100.01	y, rown or Lo		ltimore	City			M☐Yes 2 ☐ No
	28m-1	Director	10e. Street and Number	11/21		_	10f. Zip Code			10g. Citiz	zen of What Co	ountry?
	death with the Maryland ms 23a or 28a-f ahow ms 10a notified at		110 North Lakew	ood Aven	ue			21224		Uni	ited St	ates
	or ite	by Funeral	11. Marital Status  1 Never Married 2 Marne  3 Widowed 4 Divorced	Armed F	2 <b>X</b> No ve		Was Decedent of H fYes, specify Cuba 1 ☐ Yes 2€ No	ispanic Origin? (Sj in, Mexican, Puent Specify:	pecify Yes or No o Rican, etc.)		14. Race - Ame Black, Whit Specify: Wh	
15-0036	"natural",	eted	15. Decedent's (Specify only highest	Education			dent's Usual Occup		kına	16b. Kin	nd of Business	/Industry
7	within ene. then "	Completed	Elementary/Secondary (0-12)	College (		life. I	DO NOT use retired	1)		0		
N	e filed valled v	e Co	8 Years 17. Father's Name (First, Middle, L	est)		Но	usewife	18. Mother's Nan	ne (First, Middle,		n Home Sumame) [	Ink.
⊑ .		80	Charles Pratt							Mary	Y	
	d 2 should be th and Mental ?7 is marked traumatic av	-	19a. Informant's Name/Relationshi				g Address (Street					
e, ≥	s 1 and if Health item 27 other tr		Rita Sommer	(Daugl			4102 Coyo	ote Circi	e Clay		cation - City or	517
0	ages nt of the		20a. Method of Disposition		State	emetery, crer	natory or other plac					, Maryland
Бант	permit. Pages Department of the important: If its eny injury or of any inj	}	4 Donation 5 Other (Sp. 21. Signature of Furieral Service L		1/1/	20	Cemetery	se of Eacility				
ă	Depa Depa impo eny i		I fred 10	1/4	VIII		Duda-Ruck 7922 Wise	e Ave. I	oundalk,	Mar	yland	21222
			23a. Fartt. Enter the disease, or of shock, or heart failure. List of	omplications that nly one cause on	caused the deat each line.	h. Do not ent	er the mode of dyin	g, such as cardiad	or respiratory a	rrest,		Approximate Interval Between Onset and Death
F	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	_a. H1	P FRAC	TURE	WITH C	MPLICA	TIONS			31301 4110 30411
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20	tificate ig phy as the	ledic		u								
O. Box	w requires that the death certific, been signed by the attending pl should be detached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live	itcome of pregna birth 2 Feta nant at time of conown	Ideath 3	Ectopic pregnancy Other (specify)			2	23d. Date of de Month	livery Day Year
ກຸ	requires that the		Part II. Dther significant condition			-			23e. Did t	-	,	o the cause of death?
ord	require een si rould b	ted	PNEUMUNIA,	TWETIN	e pull	nowm	y DISEM	56	10'	Yes 2	<b>X</b> No 3 □ P	robably 4 Unknown
ပ္သ	e la has 18 2	Completed by	PNEUMONIA,	CONGESTI	JE HR	407 CAIL	NUS, D1.45	ETES	24a. Was autop perfo		24b. Were a prior to death?	utopsy findings available completion of cause of
<u>.</u>		င္ပ	25. Was case referred to medical					26. Place of Dea	1 Yes	2 No	1 🗆 Yes	s 2 No
		To B	examiner? 1—Yes 2 No	Hospital:	Inpatient 2	ER/Outpatier	nt 3 DOA Oth	00	lome 5 Resi		S □Other (Spe	ecify)
	ng Phys fter this ineral di		27. Manner of Death 1 □Natural 5 □ Pending	28a. Date (Moi	of Injury oth, Day Year)	28b. Time o Injury	Wor	y at k?	28d. Describe			
DIVISION	or Attanding ifter death. Diractor: After in by the fune	cat	Accident investig	ation 10/7	6/05	130	A M 1 D	Yes 2 No	SUBJE 281 Location	Street and	d Number or P	ural Route Number,
2	alor A after 1 Dirac din by	Certification:	4 Homicide determin	build build	ding, etc. (Speci	Y) A -	10ms		City or To	wn, State)	110 N.	LAKEWOOD
	To the Hospital or Attending I within 24 hours after death, To the Funeral Director: After completely filled in by the funer	edical C	29a. Certifier 1 Certifying (Check only 2 Medical B	Physician: To the	e best of my kno basis of examina	wledge, deat	h occurred at the tir vestigation, in my o	me, date and place	, and due to the	cause(s)	and manner a	s stated.
	ithin 2 o the	Med	29b. Signature and tilve of confiner	andma	nner stated.		29c. Licens				e signed (Mon	
!			1///	1 Vi	~		0	CME		Nove	mber, 1	14, 2005
	B		30. Name and address of person v	no completed cau	ise of death (Iter	n 23a) (Type,	Print)					
			MARY a.	RAU	<b>M</b>	aturo	111 P	enn Stre	et Balt	imor	e, Mary	yland 21201
	Sta Registi		31. Date fifed (Month, Day, Year) NOV 2 1	2005	Registrar's Signa	K de	ande					
DHA	AH 17 Bev 1/2		1404 × T		-	7						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Year **Physician** Nevember 14 2005 /Medical Dora Alice Smith 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Neme (If not institution, give street end number) Examiner 5. Social Security Number dale Spita 1110/0 8. Date of Birth (Month, Day, Yeer) Dec. 25, 1 If Under 24 Hrs. If Under 1 Year Birthplace (State or Foreign Country) Number **Funeral** Months Days Hours 1□ M 2/2√F 1924 Director 80 218-22-8861 Massachusetts Usuel Residence of Decedent Pages 1 end 2 should be filed within 72 hours after death with the Marylend nent of Health end Mental Hygiene. nt: If Item 27 is marked other than "netural; or items 23s or 28s-f show 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a, State or items 23a or 28a-f show 1 XYes 2 No Director Baltimore N/A Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number United States Funeral 21205 4300 Ashland Avenue 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Maritel Status Black, White, etc. 1 ☐ Yes 2√ No If Yes, Give Year or Dates: 1 ☐ Never Merried 2 ☐ Merried Maryland 21215-0020 1 ☐ Yes 2√☐ No Specify: Specify: White Completed by 3 Widowed 4 Divorced 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Own Home Homemaker vears 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Sadie Ensmain 2 James Louis Smith 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Joppa, Maryland 21085 Mrs. Linda Smith (Daughter) 3433 Clayton Road Baltimore, 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 → Burial 2 Cremation 3 Removal from State Middle River, Md. Holly Hill Cemetery 11/17/2005 Separtment 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Licensee 22. Name and Address of Fecility Duda-Ruck Funeral Home of Dundalk, Inc. 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. 7922 Wise Avenue Dundalk, Maryland 21222 Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner sician and burial-transit The law requires that the death cartificate be axecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Division of Vital Records, P.O. Box 68760, resulting in death) Last Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco usa contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of deeth? Completed 24a. Was an eutopsy performed? paga 2 should 1 Tyes 2 No 1 Tes 2DNO funerel director, Be 25. Was case referred of medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA this 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No deeth. 2 Accident investigation Director 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) à within 24 hours eftar d To the Funeral Direct completely fillad in by 4 - Homicide To the Hospital cal 29a. Certifier Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Zertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 29d. Date signed (Month, Dey, Yeer) 29b. Signature and title of certifier State 2005 Registrar

DHMH 16 Rev 6/95

		1 - For State Registrar	Sta	ate of	Maryla	•	artment of I rtificate of			,	giene Reg. No.	<b>A A A</b>	
Physicia	an	Decedent's Name (First, Midd.	e, Last)							2. Date of Dea	ath Day	Y Yea	
/Medic Examin		Edmund Swipes 4a. Facility Name (If not institution		and num	iber)		4b. City, Town, o	or Location of		Novembe:		2005 County of De	
Funeral Director		Johns Hopkins 5. Social Security Number 166-16-5755	Bayvi 6. Sex 12 M 2	7		Ctr. last birthday) Yrs.		imore If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Da Aug. 3	y, Year)		Birthplace (State or Foreign Country)
show		Usual Residence of Decedent  10a. State 10b. County				ity, Town or Lo	eation						10d. Inside City Limits
or 28a-f s	Director	Maryland 10e. Street and Number	Baltim	ore			10f. Zip Code	]	Dund		10g. Citi	izen of What	1 ☐ Yes 2 ☒ No Country?
s 23a o		3429 Liberty							1222			ited S	
filed within 72 hours after death with the Maryland Hygiene. vthar than "natural", or Items 23a or 28a-f show ant, It a Medical Executions.	by Funeral	11. Marital Status  1 Never Married 2 Mar  3 Widowed 4 Divorced	ned 1½ If Y	med For Yes Yes, Give			Was Decedent of the state of t		gin? (Spe i, Puerto	ecify Yes or No- Rican, etc.)		Black, Wi Specify:	merican Indian, hite, etc. White
s 1 and 2 should be filed within 72 hours if Health and Mental Hygiene. Itam 27 Is marked other than "natural; other traumatic event, If a Medical Exp	Completed	15. Deceder (Specify only higher Elementary/Secondary (0-12)		oleted) ollege (1-	4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during mos	t of worki	ing	16b. Ki	ind of Busines	ss/industry
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should be ind Mental ind marked c	To B	Frank Swipe		<del>-</del>						aret Sh			
and 2 sh ealth and n 27 Is m		19a. Informant's Name/Relations Florence M. Sw:	, .	,	)		ng Address <i>(Street</i> 19 Libert				-		
permit. Pages 1 and 2 Depertment of Health a Important: if Itam 27 Is any Injury or other trau	2.5	20a. Method of Disposition  p □ Burial 2 □ Cremation  4 □ Donation 5 □ Other (5)		al from S	State	cemetery, crer	sition (Name of matory or other pla S Cem. A	· .		Date			or Town, State
permit. F Depertme Importar any Injur		21. Signature of Funeral Service				Du	Name and Address Addre	ss of Facilit Funer	ăl H	ome of :	Dund	alk, I	inc.
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To the within To the comp	ž	29b. Signature and title of certifie	ir Mellen		mo		29c. Licens	e number	į.	2	29d. Date	e signed (Mor	oth, Day, Year)
0x1		29b. Signature and title of certifies  30. Name and address of person  CEORCE  31. Date filed (Month, Day, Year,	who complete	ed cause	of death (Ite	m 23a) (Type,	Print) EA	STPU	IN	mall	Cy;	303	BALTIMA MD 2122
Sta Registr	te	31. Date filed (Month, Day, Year)	2005	32 Re	gistrar's Sign	ature /		· · · · · · · · · · · · · · · · · · ·					-,

		State Unpend Item	State of Marylan 23a&27 per me	850 Clarific	ate of Death		2005	3752
		Registrar  1. Decedent's Name (First, Middle, L.			Jaio or Douir	2. Date of De		3. Time of Deal
Physici		1. Decedent's Hame (First, Middle, L	Bernard Tyr	one	Smith	Month	er 11, 2005	5 10:27 a
/Medi					City, Town, or Location of D		4c. County of Dea	
Examir	3.	4a. Facility Name (If not institution, gi		40.	·		N/A	101
		11 North Smallwoo		1 14 1 14 1 1 14 1	Baltimore Under 1 Year   If Under 24 I			rthplace (State or For
Funeral			Sex 7. Age (In yrs. 1 ■ M 2 □ F			Min. (Month, Da	V Year Ocal	ountry)
Director		219-68-2030 Usual Residence of Decedent	44			Depar	Ma.	ryland
pue *		10a. State 10b. County	10c. Cit	ty, Town or Location	1			10d. Inside City Lin
aho	৳	Maryland	N/A		Balti	more City		1√GYes 2□
Ba-f	Director	10e. Street and Number		10	ff. Zip Code		10g. Citizen of What C	Country?
vith t	吉				21223		United St	
ath v	a	2016 Penrose Av		12 Was I			- 14. Race - Am	erican Indian.
ar de	Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	if Yes	Decedent of Hispanic Origin' , specify Cuban, Mexican, P	uerto Rican, etc.)	Black, Wh	
36 safte	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	If Yes, Give	1 🗆 Y	es 21 No Specify:		Specify:	Black
Nour Pour			Year or Dates:	16a Decedent's	Usual Occupation		16b. Kind of Business	s/Industry
72 72 mg	Completed	15. Decedent's (Specify only highest g	grade completed)	(Give kind	of work done during most of OT use retired)	working		
Pen withir	E D	Elementary/Secondary (0-12)	College (1-4or 5+)	l .	bics Instruct		Recreation	n Center
Note that the true the true the true true true true true true true tru		9 Years	ctl	71020		Name (First, Middle	Maiden Surname)	
Ind be fi d oth	Be	17. Father's Name (First, Middle, La	31 <i>)</i>			a C. Levi		
VE Duld Men Men arke	2	Homer Smith		1.0				Zio Code l
Baltimore, Maryland 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Exercit er most be notified at once.		19a. Informant's Name/Relationship Ms. Lena Willia			dress (Street and Number o orth Lakewood	Ave. p	er.City or Town, State, altimore, M	arvland 2
and and nath nath		Ms. Lena WIIIIa						
Baltimore, sernit. Pages 1 ar Department of Hea mportant: If Item: any injury or other page.	١.	20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3	DRamoval from State	Place of Disposition cemetery, cremator	y or other place)	Date	20c. Location - City of	
Page Page Int: If		4 Donation 5 Other (Spec	cify) Hi.	lltop Ser	vice Corp. 11	L/15/2005	Towson, M	aryland
mit.		21. Signature of Funeral Service Lic	:ep <b>e</b> e	22. Na	ne and Address of Facility a-Ruck Funera	al Home of	F Dundalk.	Inc.
Bal permit Depar Impo		Vant a 6			2 Wise Ave.	Dundalk.	Maryland	21222
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4 11			Registrar  Decedent's Name (First, Midd									2. Date of I	Death	- 00	<del>)</del>	'S. Time's Death	_
	sicia	_	Lawrence Charle	s Simm	nc .							Month //	15	2 <i>C</i>	ear _	1:10 PM	
	edica mine		a. Facility Name (If not institution			mber)			4b. City, Town, or	r Locati	on of Death			. County of	Death		
LAG			Franklin S. Social Security Number	SOIL	iere	Hos	pita	1	Rose	di	ale			Bal	+1 j	nore	
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Direc	tor		213-28-7526	XX.	, 201	74		Yrs.				April_	23, 19	31 M	aryla	and	_
and	331	-	Usual Residence of Decedent  10a. State 10b. Count	у		10	c. City, Town	n or Lo	cation						1	10d. Inside City Limits	
Marylan f ehow		ō	MD Balti	more			Balt	imor	e							1 ☐ Yes 2X No	
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th with			925 Rosedale Ave	nue					21237					USA			
ter deat		Funeral	11. Marital Status	12	. Was Dec	rces?	r in U.S.	13. \	Was Decedent of H f Yes, specify Cuba	lispanio an, Mex	Origin? (Spicican, Puerto	pecify Yes or Rican, etc.)	No-		Americ White,	can Indian, etc.	
s after death with the Maryla	1		1 Never Married 2 Ma		1 Yes Gi	2 No			1 ☐ Yes 2💢 No	Spe	city:			Specify:	whi:	te	
		d by	3 Widowed 4 Divorce			Dates:WWI		Decer	ient's Usual Occup	ation			16b.	Kind of Busi	ness/In	idustry	-
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Hyg other		0	17. Father's Name (First, Middle	e, Last)						18. M	lother's Nam	ne (First, Mid	dle, Maide	n Sumame)			
Menta Menta		To B	Lawrence Simms							K	atharin	ne Kelly					
should have	E		19a. Informant's Name/Relatio		e, Print)				ng Address (Street					or Town, S.	ate, Zij	o Code)	
and and a salth			Joan Simms/Wif	e					Rosedale A	ve.	Baltimo	re MD 2		Location C	ity or T	own State	_
Dallillore, Mary vallor 2 12.5.5 permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene important: if item 27 is marked other than "netur			20a. Method of Disposition 1   Burial 2 □ Cremation	n 3 ∐Re	moval from		20b. Place o cemete	ry, crei	sition (Name of matory or other pla	ce)	1	Date	20c. I	Location - C	ity or 10	Swii, State	
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Dallill permit. Pag Department Important:	eny in		21. Signature of Funeral Service	e License	100			22	2. Name and Addre		Lec	onard J.					
405	a	-	23a. Part1. Enter the disease,		ations that	caused the	death Do	not ent	5305 Harfo	rd R	d. Balt h as cardiac	imore,	MD 212 v arrest.	214		Approximate	
	н		shock, or heart failure. L	ist only one	cause on	each line.										Interval Between Onset and Death	
Physic /Medi			Immediate Cause (Final disease or condition resulting in death)	_ a.	LUN	101	anc	er	(Non:	59	1491	mous	Ce	11 )			
Exami					Due to	(or)as a co	onsequence	or):		V							
	¥	er	Sequentially list conditions, if any, leading to immediate	b.	Due to	(or as a co	onsequence	of):									_
petu p	ansıt	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	1.													
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death certificate be executed eattending physicien and	he bu	cal		d.											-		
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BOX 00 death certifical attending phy	or use	Physician/M	23b. Was decedent pregnant in the past 12 months?	23		birth 2	Fetal death		□Ectopic pregnanc	у			ĺ	23d. Date Mont		very Day Year	
	ped t	/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4∐Preg 9☐Unk		ne of death	51	Other (specify) _				_				
ords, F.O. requires that the seen signed by th	detached		Part II. Other significant cond	itions conf	nbuting to	death but r	not resulting	in the u	ınderlying cause gr	ven in f	Part I.	·23e. E	id tobacco	use contril	oute to	the cause of death?	
	9	d b										4	Yes	2 □ No :	3 🗌 Pro	bably 4 Unknown	n
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has ea	89 2	Completed										ρ	erformed?	de	ath?	emptetion of cause of	
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DOT g Phy er this	<u>a</u>	ı.T	27. Manner of Death	At 1.1	28a. Date	e of Injury onth, Day Y		Time o	of 28c. Inju	iry at		28d. Descr	ibe how in	tury occurre	d		
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DIVISIO	by th	tific		old not be ermined		ce of Injury ding, etc. (		farm, si	treet, factory, office	•		28f. Location	on (Street Town, Sta	and Numbe ate)	r or Rui	ral Route Number,	
ital o	led in																
DIVISION To the Hospital or Attending within 24 hours after death. To the Funeral Director; After	completely filled	Medical	(Check only 2 Medi	fying Phys cal Examir	er: On the	basis of ex	kamination a	ge, dea and/or i	th occurred at the t nvestigation, in my	opinion	ite and place n, death occi	e, and due to urred at the ti	me, date a	(s) and mar and place, a	ner as	to the cause(s)	
the the the	eldm	Med	29b. Signature and title of er	tifier	and ma	inner state	u		29c. Licen	nse nun	nber		29d. [	Date signed	(Month	n, Day, Year)	
or √ vity To Cr	8		1 Buch	jain	ugn	M	P		RFC	FIF	nn		-11	115/0	5		
			30. Name and address of pers	ch foods	moleted ca	use of dea	th (Item 23a	) (Type	p, Print)	1)	100		1				
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1 - For State Registrar

37525

Physician
/Medical
Examiner

**Funeral** 

Director

or 28e-f show item 27 is marked other then "naturel", or items 23a or 28e-f shov other traumatic event, the Macheal Experience rust be confilted at

Director

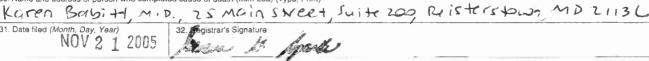
Baltimore, Maryland 21215-0036 Ā Completed permit. Pages 1 and 2 should be filed or Department of Health and Mental Hygic Importent; If item 27 is marked other any injury or other traumatic event. It Be Physician /Medical **Examiner** Examiner The law requires that the death certificate be executed use as the burial-transit and Division of Vital Records, P.O. Box 68760. the attending physician Physician/Medical signed by þ should be Completed been has page 2 certificate Be Certification: To S C After death. within 24 hours after death To the Funerel Director: the in by t filled Hospital Medical

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death NOVEMBER 16, 2005 SATISKY 12:00 A M PEARL 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death MILFORD MANOR NURSING HOME BALTIMORE BALTIMORE 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 10/20/1911 9. Birthplace (State or Foreign Country) AUSTRIA 5. Social Security Number 1 □ M 2 🕡 F 218-10-8072 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1 ☐ Yes 2 ¥☐ No BALTIMORE BALTIMORE 10e. Street and Number 10f Zin Code 10g, Citizen of What Country? 4204 OLD MILFORD MILL ROAD U.S.A. 21208 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married WHITE 1 ☐ Yes 2 No 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) **HOUSEWIFE** OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) AWNER SARAH PAPIER SAMUEL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6802 WELLWOOD COURT - BALTIMORE, MD 21209 MIMI GETLAN / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 11/18/2005 CHIZUK AMUNO CONG. BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service kicensee Sta 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between Onset and Death Immediate Cause (Final disease or condition Alzheimer's Disease resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate the list in the Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Bunknown 1 ☐ Yes 2 ☐ No. 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 2 🗆 No 1 Yes 2 No 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 1 Hatural 28b. Time of 28d. Describe how injury occurred Injury 5 Pending 1 Tes 2 No investigation 2 Maccident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) 1 2005



DO058676

November 16, 2005

man Balettin

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Warren 6:25 AM **Physician** 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death Examiner Howard Gerein Howard County Columbia If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year), OZ · IZ · IQZA Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number **Funeral** Days 1 MM 2 □ F 81 01110 218.14.9910 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State Item 27 is marked othar than "naturel", or Itams 23a or 28a-1 ehow othar traumstic event. Its Medical Examinar must be meltial at 1 □ Yes 2 No Director MD HOWARD ELLICOTI CITY 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21042 USA 10112 LAKESIDE Court Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. e filed within 72 hours after cal Hygiene. I Hygiene. I othar than "naturel", or Itan 1 X Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Specify: BLACK Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: چ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Coilege (1-4or 5+) Elementary/Secondary (0-12) DEPT. OF CORRECTIONS ADMINISTRATIVE JUDGE 1214 GRADE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or othar traumatic event Be EUGENE TILLEY MARIE SMITH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 836 GLEN ALLEN DR. BALTIMORE MD
ace of Disposition (Name of 20c. Location - City WARREN TILLEY 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State `4 ☐ Donation 5 ☐ Other (Specify) GARRISON FOREST 11.29.05 OWINGS MILLS, MD VAUGHN C. GREENE FUNERAL SERVICE 21. Sign ture of Funeral Service Licens 5151 BAUTO, NATU PIKE, BAUTO, MD 21229 angha 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final COVONAIG Artera Priysician disease or condition resulting in death) /Medical Due to (or as a con uence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Under in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner use as the burial-transit death certificate be executed Due to (or as a consequence of): the attending physician hed for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown ò 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part L Division of Vital Records, þ ed bluods 3 ☐ Probably 4 ☑ Onknown Discase 1 ☐ Yes 2 ☐ No Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 certificate 1 Tyes 2 1 No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 W No Certification: To After the funeral 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Płace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide

the Hospital or Attanding Physician: after death a Funarat Dire within 2

29a. Certifier

(Check only one)

Medicai

State

Registrar

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

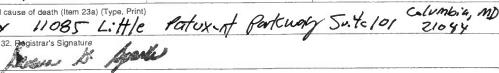
Attending Physician

D0061309

29d. Date signed (Month, Day, Year) 11.19.2005

who completed cause of death (Item 23a) (Type, Print) L:H/e 11085

NOV 2 1 2005



05-07622 Louis Tally

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

is lairy	State of Maryland Department of Health and More State Unpend Item 23a&27 per me 6850 12-7-05 tages than a	ental Hygien	9
	Registrar Amend Item 8 per dvr G850 Certificate of Death 12-8-	-05 tasneg M	5005 31521
Physician	1. Pacedent's Name (First, Middle, Last)	2. Date of Death Month Da  November 1	M
/Medical Examiner	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death		1, 2005 07:06 A
	St. Agnes Hospital  5. Social Security Number.  6. Sex / 7. Age (In yrs. last birthday) If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	N/A
Funeral Director	5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year   If Under 24 Hrs.   Months Days Hours Min.	7-20-1981	Bidthplace (State or Foreign
	Usual Residence of Decedent  10al State 10bl County 10c. City, Town or Location		10d Inside City Limits
Marylan Hed at tor	Hd. Baltinore Co		1 ☐ Yes 2 ☐ NO
or 28a-1 se notifie	10e. Street and Number 10f. Zip Code	10g. C	itizen of What Country?
Site death with the Mar riteme 23e or 28e-1 et niner must be noutfled Funeral Director	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specific Forces) If Yes, specify Cuban, Mexican, Puerto Forces	cify Yes or No-	14. Race - American Indian,
030 urs a	1  Never Married 2  Married		Black, White, etc.  Specify: Black
121215-0 1 within 72 ho liene. r than 'natur the Wedical	15. Decedent's Education (Specify Inly highest grade completed)  (Give Ind of work done-during most of working life. DO In Tuse retired)	16b. F	(ind of Business/Industry
21215-00 ed within 72 hou signerne. Instrum naturur, t, the Medical Completed	Elementary/Seksin/ary (0-12) College (1-4or 5+)	10	yota Motors
m same i	17. Patter's Name (First, Middle, Last)  18. Mother's Name  18. Mother's Name	(First, Middle, Maide	nySimame) -
Maryland d 2 should be file th and Mental H it is marked oth traumatic even	19 Informant's Name/Relationship (Type, Prigit) 19b. Mailing Address [Stryet and Number or Rurgi	Route Number City	or Town, State Zip Code)
C = 01 L	Kucele Branford/Hother 40/ Haple Sa	re Del	1 MOL 2/222
	20a. Method of Disposition  20b. Blace of Disposition (Nafne of Cemetery, cremtiony or tither place)	20c. L	ocation - City of Town, State
Baltimo	4 Domation 5 Other (Specify)  21. Signature of Funeral Service Licensee  22. Name and Ageress of Facility	1/ en tri	KIRA SERVICE
Ba Permi Depe Impo Impo	Hurnelof Coon 2 1018/12abeth	The B	alt Mot 2/225
	23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dyug, such as cardiac or shock, or heart failure. List only one cause on each line.  Immediate Cause (Final	respiratory arrest,	Approximate Interval Between Onset and Death
Physician /Medical	disease or condition resulting in death)  Cardiomegaly and Obesity  Due to (or as a consequence of):		
Examiner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):		
executed on and ial-transit	cause. Enter Underfying Cause (Disease or injury		
760, be executed sicien and burial-transit	resulting in death) Last	The state of the s	
68760, ifficate be expension as the burial edical E	d		
Box 6  Box 6  auth certific attending F for use as	IF FEMALE: 23b. Was decedent pregnant  23c. If yes, outcome of pregnancy  1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of delivery
P.O. Box 68 has the death certificated by the attending pt letached for use as it.	in the past 12 months?  1   Yes   2   No   4   Pregnant at time of death   5   Other (specify)   9   Unknown   9		Month Day Year
IS, P.O. res that the digned by the be detached by Physic	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
Cords, w requires to been signer should be o		1 Tes 2	Probably 4 ☐Unknown
Il Record The law requir cate has been s page 2 should		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
Division of Vital Records, to Attending Physicien: The law requires tatler death. Director: Atter this certificate has been signed in by the funeral director, page 2 should be ertification; To Be Completed by	25. Was case referred to medical 26. Place of Death	1XT Yes 2 □ N	
of Vi	examiner?  1 Y Yes 2 No  Hospital: 1 Inpatient 2 YER/Outpatient 3 DOA  Other: 4 Nursing Hon	ne 5 Residence	
on C ding P h. After t funera	1 Manual 5 Pending (Month, Day Year) Injury Work?	8d. Describe how inju	ury occurred
Division ( tel or Attending P ts after death. el Director: Alter t ed in by the funers Certification;	2 Accident	28f. Location (Street a City or Town, Star	nd Number or Rural Route Number,
Ditel or urs after or orel Direction			
Division of Vital Records, P.O. Box 687  To the Hospitel or Attending Physicien: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the Medical Certification; To Be Completed by Physiclan/Medic	29a. Certifier  (Check only one)  Check only one  And manner stated.	ind due to the cause(s ed at the time, date ar	s) and manner as stated. nd place, and due to the cause(s)
To th within To th comp	29b. Signature and title of certifier 29c. License number		ate signed (Month, Day, Year)
	Morgane me Gall My O.C.M.E.	Nov	vermber 12, 2005
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  MDRUD COND D. KOREW 111 Penn Street, Baltimo	re, Maryla	and 21201
State	31. Date filed (Month, Day, Year) 32. Registrar's Signature		
Registrar DHMH 17 Rev 1/2001	NOV 2 1 2005 Read & Speciel		

			1 - For State Registrar	State of Maryl		artment of Heartificate of De		ental Hygier	2005	37528
ij.	Physici		Decedent's Name (First, Middle, Last)	Anna M.	Taylor			2. Date of Death Month	Day Year	3. Time of Death 7:00 A M
	/Medic Examin	161	4a. Facility Name (If not institution, give str Greater Baltimore	eet and number) Medical Ce		4b. City, Town, or Lo	ocation of Death		16 2005 4c. County of Death Baltimor	1
	Funeral Director		5. Social Security Number 6. Sex 10.1	/ 3√F	vrs. last birthday) Yrs.	ff Under 1 Year If	Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birth	nplace (State or Foreign untry)
15.	9		Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or Lo	cation		Oct. 27,	1921 Mar	yland  10d. Inside City Limits
	Ba-f ehc	Director	Maryland Baltimo	re			Towson			1 ☐ Yes 2 ☑No
	th with the		10e. Street and Number  1013 Timber Tra	ail Road		10f. Zip Code	21204		Citizen of What Co Jnited St	
036	72 hours after death with the Maryland naturel', or flerne 23a or 28a-f e how digal Executer fourthe notified at	by Funerai	11. Marital Status 12  1 Never Married 2 Married 3 Widowed 4 Divorced	. Was Decedent Ever i Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of Hispa f Yes, specify Cuban, f 1 ☐ Yes 2 ☑ No 3	anic Origin? (Spec Mexican, Puerto R Specify:	offy Yes or No- lican, etc.)	14. Race - Amer Black, White Specify:	
21215-0036	within ane. then	Completed	15. Decedent's Educa (Specify only highest grade Elementary/Secondary (0-12) 12 Years	tion completed) College (1-4or 5+)	(Give	dent's Usual Occupation kind of work done during the NOT use retired)  Homemaker	on ing most of workin	g 16b.	Kind of Business/l	ndustry
pue	be filed ntal Hygi od other event, I	Be	17. Father's Name (First, Middle, Last)					(First, Middle, Maid		<u>e</u>
Maryland	2 should be and Mental Is marked o eumatic eve	J	David Lee  19a. Informant's Name/Relationship (Type	o, Print)	19b. Mailir	ng Address (Street and		Ruth Nize		ip Code)
	Health em 27 ther tr		Mr. Albert H. Taylo		b. Place of Dispo	.3 Timber T sition (Name of	rail Roa		n, Maryla: Location - City or 1	
Baltimore,	0 0		1X Burial 2 □ Cremation 3 □ Rei 4 □ Donation 5 □ Other (Specify)		•	natory or other place) Cemetery 1	1/19/200			Maryland
Ball	perrait. Pag Department Important: any injury o		21. Signature of Funeral Service Licensee	2	I	Name and Address of Ouda-Ruck F 922 Wise A	uneral H	ome of Du	ındalk, I: vland 21	nc. 1222
	Physician /Medical		23a. Part1. Enter the disease, or complice shock, or heart failure. List only one firmediate Cause (Final disease or condition resulting in death)	cause on each line.	neum	•	such as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death
1	Examiner			Due to (or as a con	sequence of):	>				years
8760,	cate be executed oblysician and the burial-transit	ai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a con	Rheun	natoid a	ertwit	is		years.
9	artificate ing phys e as the	Medic	d.							
.O. Box	at the death certifica by the attending pt tached for use as ti	Physiclan/Medical	23b. Was decedent pregnant in the past 12 gronths? 1 Yes P No 9 Unknown	b. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time 9 ☐ Unknown	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of delin Month	very Day Year
ords, P	The law requires that the ste has been signed by the bage 2 should be detached.	٥	Part II. Other significant conditions contr	ibuting to death but not	resulting in the u	nderlying cause given i	in Part I.	23e. Did tobacc		the cause of death?
of Vital Records,		Completed						24a. Was an autopsy performed 1 ☐ Yes [2 ☐ 1	prior to co	opsy findings available ompletion of cause of
f Vit	g .s. 5	To Be	25. Was case referred to medical examiner?  1  Yes No Ho		2 ☐ ER/Outpatien	Other	6. Place of Death 4 □ Nursing Hom	(Check only one) e 5 ☐ Residence	6 □Other (Spec	ify)
	After After	atlon:	27. Manner of Death   Natural 5   Pending   Pending investigation	28a. Date of Injury (Month, Day Yea	r) 28b. Time of Injury	Work?	28 s 2 🗆 No	8d. Describe how in	jury occurred	
Division	- 6	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Sp	At home, farm, str ecify)	eet, factory, office	28	Bf. Location (Street City or Town, Sta	and Number or Rui ite)	al Route Number,
	To the Hospitel of within 24 hours at To the Funerel Completely filled in	edical (	29a. Certifier 1 Certifying Physic (Check only one) 1 Medical Examine	r: On the best of my r: On the basis of exam and manner stated.	knowledge, death nination and/or in	n occurred at the time, vestigation, in my opinio	date and place, ar	nd due to the cause d at the time, date a	(s) and manner as nd place, and due	stated. to the cause(s)
	To t To tl	Ž	29b. Signature and title of certifier	- MD , N	19+1	29c. License nu	0 440	29d. E	Datersigned (Month)	Day, Year)
1	01		30. Name and address of person who com	pleted cause of death (	Item 23a) (Type,	STOIN C	havles	St. Tou	VSON N	VD 21204
for the	Sta Registi		31. Date filed (Month, Day, Year)  NOV 2 1 20	32. Resistrar's Si	ignature	book		, , , ,	•	,

ADH JOAN WASHINGTON 05-7621

621			1 - For Registrar	State of Mary b per FH G84	land / Depa 49 11/23/	artment of	f Health a	nd Mental Hyg	jiene .g. N2 N N 5	27520
	# w	κ .	Decedent's Name (First, Middle, Las					2. Date of Dea	th	3. Time of Death
	Physici /Medio		Joan Roslyn Wa	shington				NOVEMBI	ER 11, 200	5 0555 A <sup>M</sup>
	Examir		4a. Facility Name (If not institution, given 28TH STREET AND G		VENUE	4b. City, Town	n, or Location of 10RE	Death	4c. County of De	ath
AC.	Funeral Director		5. Social Security Number 6. Security Number 213-58-3174	9x	yrs. last birthday) Yrs.	If Under 1 Ye Months Da		4 Hrs. 8. Date of Birth (Month, Day Aug. 3	(Year)	irthplace (State or Foreign Country) Maryland
	and w		Usual Residence of Decedent  10a. State 10b. County	10-	c. City, Town or Lo	ocation				10d. Inside City Limits
	the Marylan 28a-f ehow notified at	tor	Maryland N/A		Baltimo					M∏Yes 2 No
	with the	I Direc	10e. Street and Number 4014 Eldorado	Avenue		10f. Zip Coo	21215		10g. Citizen of What (	Country?
036	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If Itam 27 is marked other than "natural", or iteme 23a or 28a-f ehow or other traumatic event, the Medical Examiner must be notified at or other traumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates:		Was Decedent	of Hispanic Orig Cuban, Mexican,	in? (Specify Yes or No- Puerto Rican, etc.)	14. Race - An Black, Wh Black Specify:	
21215-0036	within 72 ho iene. than "natur the Medical	Completed by	15. Decedent's Ed (Specify only highest gra	ucation de completed) College (1-4or 5+)	(Give	DO NOT use re	ne durina most	of working	16b. Kind of Busines 'ederal G	s/Industry overnment
S	ld be filed wental Hygie kad other tice event. It	Be	12 years  17. Father's Name (First, Middle, Last)  Hilton McDanie		OTOL		18. Mother Evel	's Name <i>(First, Middle,</i> yn Matthe	Maiden Sumame) PWS	-
Maryland	nd 2 should tith and Ment 27 is marked r traumatic o	2	19a. Informant's Name/Relationship (7 Terri Hayes/ Da	Type, Print)	19b. Mailii 4014	ng Address (Str Eldor	eet and Number ado Av	or Rural Route Number venue Balt	r, City or Town, State	Zip Code) 21215 laryland
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If Itam 27 Is eny injury or other tra once.		20a. Method of Disposition  1  → Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specify	Removal from State	<u>Α</u> ΄	matory`or other	place) 11	/17/20050	20c. Location - City of Crownsvil	
Balti	permit. Departm Importa eny inju		21. Signature of Funeral Service Licen	lee Lin	Crownsvi 5	2. Name and Ad	Idress of Facility	iatman-Har	ris Fune Baltimore	eral Home e,Md 21215
	Physician /Medical		23a. Part Enter the disease, or come shock, or heart failure. List only impediate Cause (Final disease or condition resulting in death)		innes	er the mode of	dying, such as c	ardiac or respiratory are	est,	Approximate Interval Between Onset and Death
8760,	cate be executed physician and ithe burial-transit	dical Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to for as a co						
Box 6	death certifi e attending ed for use as	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	⊒Ectopic pregna ⊒ Other (specify		VŽ.	23d. Date of d Month	elivery Day Year
ds, P.O.	8 6 6	b	Part II. Other significant conditions o	ontributing to death but no	ot resulting in the u	nderlying cause	given in Part I.	23e. Did to	1.	to the cause of death?
Vital Records,	The law ate has by page 2 sh	Completed						24a. Was a autop: perfor	sy prior to	autopsy findings available completion of cause of
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Othor	of Death Check only or		ecity) SCENE
of	ig Phys ter this neral di	n: To	X Yes 2 No 27. Manner of Death	28a. Date of Injury	2 ER/Outpatier		njury at Work?	sing Home 5 Resid	ence 6 AOther (Sp ow injury occurred	ecity) SCEIVE
ion	± - ₹ 5	atlo	1 □Natural 5 □ Pending 2 □Accident investigation	NOV IL COOL			work? 1 □ Yes 2 🔼 N	10 parent	e Collisia	0/
Division of	To the Hospital or Attending I within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, sti Specify)	reet, factory, off	ice	City or Tow	treet and Number or	Rural Route Number, Mint Ave More MD
	Hospital 4 hours Funeral tely filled	ledical	(Check only 2 M Medical Exam	ysician: To the best of m	amination and/or in	h occurred at th	e time, date and ny opinion, death	place, and due to the of hoccurred at the time, of	ause(s) and manner late and place, and d	as stated. ue to the cause(s)
	To the within 2 To the complet	Med	29b. Signature and title of certifier	and manner stated.		29c. Lic	ense number	1	29d. Date signed (Mo	nth, Day, Year)
	⊢ 3 ⊢ ŏ \		1 fort	seef n	w		OCME	I	NOVEMBER	11, 2005
	P	3	30. Name and address of pers n who	1 1 10			- የተያ ፑፑጥ	BALTIMORE,	ΜΔΡΥΙ.ΛΝΙ	21201
	30 M	ate	31. Date filed (Month, Day, Year)	Devis M.D.  32. Registrar's	a: .		JINDI,	PRILITIONE,	, MINITIANIA	212VI
	Regist			2005	B. B.	medi				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. edent's Name (First, Middle, Last 2. Date of Death 3. Time of Death Year **Physician** 20 NOV 2005 /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner utimore Age (In yrs. last birthday) Under 24 Hrs. Date of Birth (Month Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min Director the Maryland 10c. City Town or Location 10a State 10d. Inside City Limits 27 is marked othar than "natural", or Itams 23a or 28a-f show traumatic avant, the Modical Exercit or must be notified at 1 □Yes 2 No Funeral Director 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 21133 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Important: If itam 27 is marked othar than "natural", or Itar 1 Tes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. þ 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life\_DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maided Surname) Bivins James nomas ocation - City or Town, State 1 ■Burial 2 □ Cremation 3 □ Removal from State ō 5 Other (Specify) any town, mD 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Le. hen /Medical Examiner 50 Sequential v list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as 1 co sequence of) burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) P.0. the 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by Mia 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan 2 2 No 1 ☐ Yes To the Hospital or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No P 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this Date of Injury (Month, Day Year) 28b. Time of 27. Manne of Death 28d. Describe how injury occurred After t Certification: 5 Pending investigation 1 Natural death. 2 🗆 No 2 Accident Diractor: 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \( \text{Homicide} \) within 24 hours a To tha Funaral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 44817 aM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Registrar

31. Date filed (Month, Day, Year)

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32. Regist 's Signature

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1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

\*\*Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) **OCME** November 7, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street Baltimore, Maryland 21201 M.D JAIK

State Registrar

31. Date filed (Month, Day, Year)

2005

32 Registrar's Signature doors.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Dolores A. Wladkowski November 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Union Memorial Hospital Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min. 1 ☐ M 2√2 F Yrs Director 219-42-2401 63 June 21, 1942 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rthan "natural", or Itame 23a or 28e-f ehov the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland N/ABaltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death v by Funerai 511 S. Kenwood Avenue 21224 United States Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours atter 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ₩ No Specify: Specify: White 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Pages 1 and 2 should be filed v tment of Health and Mental Hygie tent: if Item 27 is marked other t jury or other treumatic event, In Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Stanley Kokoszki ပ Ann Kocon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard D. Wladkowski (Husband) 511 S. Kenwood Ave. Baltimore, Maryland 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Importent: if any injury or once. Sacred Heart of Jesus 11/17/2005 Dundalk, Maryland Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222 23 Part Effect the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** pleura malionant Dwecks /Medical Due to (or as a consequence of) Examiner DEUTIVIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner rsicion and o burial-transit or Attending Physicien: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Be Completed by Physician/Medical the attending phys for use as the 25 IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the al 9 Unknown 9 ☐ Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably Unknown certificate hes b irector, page 2 sl 24a. Was an autopsy performed? Yes 2 No No No 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Medical Certification; To 1 ☐ Yes 2 No Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Natural 2 Accident 5 Pending within 24 hours atter death. To the Funerel Director: A completely filled in by the fu М 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \( \text{Homicide} \) Hospitel (Excitiving Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only the e 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Nov 13, 2005 AT2433946 who completed suse of death (Item 23a) (Type, Print) 201 E. University Pkwy Baltimore, mo 21218 Angela Molacy 31. Date-filed (Month, Day, Year) State Registrar

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		State Registrar		C	ertificat	e of E	eath			. Na. U	J5_	37533
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vequires that the death certificate been signed by the attending phe should be detached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	ne of pregnancy 2  Fetal death	3 □Ectopic p	regnancy				23d. D.	ate of delive	
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		30. Name and address of person		f death (Item 23a) (Ty OI LOCH RI	pe, Print)	30UL1	EVAV	20.	BALTIM	CRE .	MD :	21239.
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** daude 12:308 2005 /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore recours If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 239-40-2737 Days 100M 20F Hours 73 Months NORTH CAROLINA Director TANOL. Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits wohe ed other than "naturel", or Items 23a or 28a-f ehov event. It e Modical Examiner must be notified at 1 XYes 2 No Director 10e. St 10g. Citizen of What Country? eet and Number death with Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Specify: BLACK À 3 ☐ Widowed 4 ☑ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) nd Mental Hygiene. marked other than 7+HGRADE LUMBER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be filt freen of Health and Mental Hy tent: If Item 27 is marked oth jury or other treumatic event Be TAMES 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22 NORMANDY AVE. VIOLA WITHERSPOON (SISTER) BALTO. MD. 21229 altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages I Department of H Importent: If Ite any injury or ot 1. Burial 2 ☐ Cremation 3 ☐ Removal from State CEMETERY 11-28-05 BALTIHORE 4 ☐ Donation 5 ☐ Other (Specify) Pacifig BROWN JR. FUNERAL HOME 22/Na 21. Signature of Funeral Service Licenses N. FULTON AVE. BALTO, MD. 212 rice 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory frest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine requires that the death certificate be executed as the burial-transit Due to (or as a consequence of): attending physiciar Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. 9□ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an The law autopsy performe page this certificate 2 No 1 Yes 2 40 or Attending Physician: 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one, Hospital: Other: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient funeral dir 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After Year) 1 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation the f 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) in by t 4 Homicide within 24 hours a To the Funerel I pelli 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29d. Date signed (Month, Day, Year,

State Registrar

29b. Signature and title of certifier

30. Name and address of person

31. Date filed (Month, Day, Year)

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of death (Item 23a) (Type, Print)

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Baltimore

32. Begistrar's Signature

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	ryland how		10a. State 10b. County		10c. Cit	y, Town or Lo	cation					10d. Inside City Limits
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36	be filed within 72 hours after death with the Maryland all Hygiene. Hygiene 194 other than "natural", or iteme 28a or 28a-f ehow other than "natural", or iteme 28a or 28a-f ehow event, Ite Madical Examiner must be notified at	by Fu	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	ed 1 X Yes If Yes, Gi Year or D	2 Q No 194	14	1 □ Yes 2 No	Specify.		, 0.0.,	Specify: Wh	
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	1 and Health em 27 ther tr		Julia E. Acker	, Wife	20b. F		Maiden Ch	oice	Lane C		ille, MD 2	
TOL	ages ant of i nt: if its		1 ☐ Burial 2 ☑ Cremation  4 ☐ Donation 5 ☐ Other (Sp		State	emetery, crer	matory or other place ematory		11/21		Baltimore,	
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ita	ician: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?					26. Plac	e of Death (C	1 ☐ Yes 2 heck only one)	110 10165	3/21/10
of V	Physician: this certificatal director, I	은	1 Yes 2 No			ER/Outpatier		4 N			e 6 Other (Spec	eify)
Ou	nding Phy fh. : After thi s funeral o	tion	1 Natural 5 Pending 2 Accident investig		of Injury oth, Day Year)	28b. Time o Injury	Wor	yaı k? Yes 2.⊑		Describe now	injury occurred	
Division	r Atter er dea rector by the	Certification;	3 Suicide 6 Could r	ot be 28e. Place	e of Injury · At h	ome, farm, str fv)	reet, factory, office		28f.	Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
۵	urs aft orai Di											
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.	edicai	29a. Certifier Certifyin (Check only one)  2 Medical	Examiner: On the b	e best of my kno pasis of examina nner stated.	owledge, deat ation and/or in	h occurred at the tir vestigation, in my o	ne, date a pinion, de	nd place, and ath occurred a	due to the caus at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
	To the within To the compl	Me	29b. Signature and title of certifier	- / ^			29c. Licens	e number	110		. Date signed (Month	4.00
	1		Mark	0.16	und	M.D	. 040	1/	48	N	OVEMBER	19,2005
	7		30. Name and address of person		se of death (Iter			Choic	e Lane	Catons	ville, MD	21228
	Sta	ite	31. Date filed (Month, Day, Year)	32. 1	Registrar's Signa	ature						
340	Regist	ar	NOV 2	2 2005	Safeas.	13 A	ball					

		For State Registrar	State of Maryland	d / Depa <i>Cer</i>	artment of H	ealth and Death		giene	05	37536	
Physici	an	Decedent's Name (First, Middle, Last)				2. Date of De Month		Year	3. Time of Death		
/Medic	cal	I havesa	Amus	~	# C't T		11	20	2005		
Examin	er	4a. Facility Name (If not institution, give si	reet and number)		4b. City, Town, or	Location of Dea	" LLN		nty of Death ne Arui		
Franci	7	5. Social Security Number 6. Sex	7. Age (In yrs. In	ast birthday)	If Under 1 Year	If Under 24 Hrs	8. Date of Birt	th	9. Birtho	place (State or Foreign	
Funeral Director		144-01-5858	M 2 F 92	Yrs.	Months Days	Hours Min		, 1913	New	Jersey	
P .		Usual Residence of Decedent									
arylar ehow	_	10a. State 10b. County		, Town or Lo	cation				1	10d. Inside City Limits 1 ☐ Yes 2 ☑ No	
ith the Marylar or 28a-f ehow	ecto	Maryland Anne Arus  10e. Street and Number	ndel A	rnold	405 7:- O-d-			10g. Citizen	-6.14/b-s-4.C		
If it is in the Maryland filed within the Maryland Hygiene.  Hygiene.  Sther than "natural", or Items 23a or 28a-f show ent, the Medical Examinational be indiffed at	Funeral Director	496 Colonial Ridge Lane			10f. Zip Code 210		United States				
72 hours after deeth w "natural", or items 23a	erai	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Ye If Yes, specify Cuban, Mexican, Puerto Rican, 6			or No-  14. Race - American Indian, (c.) Black, White, etc.			
or Iter	F										
Sours e	1 by				1 ☐ Yes 2 🕱 No Specify:				Specify: White		
72 h	Completed	15. Decedent's Educ (Specify only highest grade	(Give	ient's Usual Occupa kind of work done o	orking	16b. Kind of Business/Industry					
the within	ig m	Elementary/Secondary (0-12) College (1-4or 5+)			Secretary			Dair Products Mfg.			
Hygie ther ther ther ther		17. Father's Name (First, Middle, Last)			becretary	18. Mother's Na	ame (First, Middle,			ts mg.	
ite; IMAI yian G IZIOOOOO	o Be	John L. Coman			Ella Gree						
and Name		19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailin	ng Address (Street a	ın <i>d Number</i> or P	Rural Route Numbe	er, City or Tov	wn, State, Zip	Code)	
and and m 27		Dennis Ammon, Son	1	3 Cay	yuga Trai	1 Road,					
Pages 1 nent of H int: If Itel iry or oth		1 M Burial 2   Cremation 3   Hemoval from State			natory or other place	Date		Location - City or Town, State			
then tant:		'4 □Donation 5 □ Other (Specify)		Cemetery 11/26/2005 22. Name and Address of Facility Clark, Winter			Walton, New York				
permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra		21. Signature of Funers Service Ligende	M01113		Townsend S					CHETAL HAL	
		23a. Part1. Enter the dise se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failuin. List only one cause on each line.  Approximation of the disease of the death of the d							Approximate Interval Between		
Physician		shock, or heart failur. List only one cause on each line.  Interval Immediate Cause (Final disease or condition resulting in death)  Due to (or of a consequence of):								Interval Between Onset and Death	
/Medical									r days		
Examiner		One constally the constaline	Sero	sis	30	420		yeurs			
70 ≅	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying									
ecute a d	Po po po po po po po po po po po po po po										
ate be ex hysician the burial			Due to (or as a consequ	ience or).							
icate phys	edicai	d.									
n certifi inding use a	N/M	IF FEMALE: 23b. Was decedent pregnant	ncy			23d. I	23d. Date of delivery				
death death e atte	FFEMALE: 23c. If yes, outcome of pregnancy   1								Month Day Year		
by the tache	hys	9 Unknown	9□ Unknown								
es the	by	Part II. Other significant conditions continuous to dealin out not resoluting in the underlying cause given in Part I.									
een si	ted	Unleague metaltata concer,							Yes 2 No 3 Probably 4 Unknown		
law las b	Completed	Obreve rend falure				24a. Was autop	osv	24b. Were autopsy findings available prior to completion of cause of			
The The cate of page	S						1 ☐ Yes	rmed? 2 No	death? 1  Yes	2 □ No	
vician tician certifi	Be	25. Was case referred to medical examiner?	ospital:		26. Place of Death (Check only one) Other: 4   Nursing Home   5   Positions   6   10						
Phys Carthis and did	.: To	1 Yes 2 No	1 Suppatient 2 EN/Outpatient 3 DOA 4 Nursing Hot					me 5 Residence 6 Other (Specify)  28d. Describe how injury occurred			
nding Phy th.: After this s funeral o	tior	1 Natural 5 ☐ Pending investigation	(Month, Day Year)	In <del>j</del> ury	Work	t? Yes 2 ☐ No					
Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)			
rs after ral Dir	Cert	Dulluling, etc. (opecity)									
To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medicel Exemin	ician: To the best of my know er: On the basis of examinat and manner stated.	wiedge, death ion and/or inv	n occurred at the time vestigation, in my op	e, date and place pinion, death occ	e, and due to the curred at the time,	cause(s) and date and plac	manner as s e, and due to	stated. o the cause(s)	
To the Mithin Fo the comple	Me	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)							Day, Year)		
. ,,,		100	Lin MD		Dog	06178	3	11	1201	2005	
V		30. Name and address of person who completed cause of death (Item 23a) (Type, Print).  Change Charge, 2003, Medical Rung, Jungpolis, MD 21401									
`			200) Medi	cay	King	, June	porcs,		214	to1	
Sta Regista		31. Date filed (Month, Day, Year) NOV 2 2 200	3 Registrar's Signal	Ture /			1				

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Please Type of Print in	black indelible link.	Lilouic All	Cobies Wie	region

			For State Registrer	State		d / Depa	artment of H	ealth and M	ental Hyg	giene 0 0	5	37537
	5 3 TO .		1. Decedent's Name (First, Midd	le, Last)					2. Date of Dea Month		r'ear	3. Time of Death
	Physicia /Medic		SHIRLEY LEE	AULD			· · · · · · · · · · · · · · · · · · ·		NOV.	15 200	J5	10:00 P⁴
	Examin	er	4a. Facility Name (If not institution	n, give street and r	number)		4b. City, Town, or			4c. County of		
		* 14	STELLA MARIS 5. Social Security Number	6. Sex	7. Age (In yrs.	iast hirthday)	TOWSC		8. Date of Birth	BALTI		ace (State or Foreign
	Funeral Director		215~18~9581	1 ☐ M 3√3√F		Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day Sept. 27	7, 1923 <sub>M</sub>	Count arvl	ace (State or Foreign try) and
	ס	8	Usual Residence of Decedent		40- 00							
	ehow	J.	10a. State 10b. County Maryland Harfo			y, Town or Lo Ahinada	on - Harfo	ard Counts	A.		11	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
	the M	Funeral Director	10e, Street and Number			DINGU	10f. Zip Code	ora coone	,	l0g. Citizen of Wh	nat Coun	
	with Mith	וַם	307 D Tall Pin	es Court	Ant 4		210	ากด		USA		
	me 2;	лега	11. Marital Status	12. Was De	ecedent Ever in U. Forces?	.S. 13.	Was Decedent of Hi If Yes, specify Cuba		cify Yes or No-		- America White, 6	
9	or Its	/ Fui	1 ☐ Never Married 2 📉 Mar	ned 1 ☐ Ye	s XX No		~	Specify:	nicari, etc.)	Specify:		
21215-0036	within 72 hours after death with the Maryland ene. then "naturel", or Iteme 23a or 28e-f ehow ta Medical Exeminar maist be mulliad at	d by	3 Widowed 4 Divorce	Year o	Dates:			tion	1			
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212	filed with Hygiene. other ther	mo	Elementary/Secondary (0-12)	N/A	(1-4or 5+)	Col	lector			Banking	Ind	ustry
	be filed tal Hyg d othe	Bec	17. Father's Name (First, Middle	Last)				18. Mother's Name		Maiden Sumame,	)	
<u>   </u>	Menta narked	To	Murvin Barker						Lyman			
Maryland	2 st and le n		19a. Informant's Name/Relation				ng Address (Street a			-		
	1 and Health em 27 ther t		Harry E. Auld 20a. Method of Disposition	(nuspand)			) Tall Pir psition (Name of matory or other place		Date	LINGOON, 1 20c. Location - C		
Baltimore,	nt of I		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (	3 □Removal fro	m State			1	0.05			
Ē	ertme ortani injury		21. Signature of Funeral Service		Met	2	ematory Ir 2. Name and Ad <u>dr</u> es	s of Facility		Baltimore	3, M	<b>a.</b>
Ba	permit. Deperte Importe eny infe		1 8. J. XX	socker		<u> </u>	assahn Fu 401 Belai	neral Hom r Bd. Bal	ne timore.	Md. 212	236	
V	Physician /Medical Examiner putansit putansi putansi putansi putansi putansi putansi putansi putansi putansi putansi putansi puta	Examiner	23a. Part1. Enter the disease, c shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, Tany, heading to ammediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. CER Due b. Due c.	EBROVASCI to (or as a consequence of the consequence)	ULAR A uence of):		g, such as cardiac c	n respiratory an	est.		Approximate finterval Between Onset and Death
P.O. Box 68760,	death certificate e ettending phy: od for use as the	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼No 9 □ Unknown	1⊡Liv 4⊟Pre	outcome of pregna e birth 2 Feta egnant at time of d known	if death 3	⊒Ectopic pregnancy □ Other (specify)			23d. Date Mont		ry Day Year
	= 0 73	ğ	Part II. Other significant condit	ions contributing to	o death but not res	sulting in the u	inderlying cause give	en in Part I.				e cause of death? ably 4XJUnknown
Records,	e law hes b	Completed							24a. Was a autop perfor	sy pr med? de	ere autorior to contath?	psy findings available inpletion of cause of
Vital	sician: Th certificete rector, pag	Be	25. Was case referred to medic examiner?					26. Place of Death	Check only or	78		
of V	Physiclan: this certific al director.	မ	1 ☐ Yes 2 📉 No		☐ Inpatient 2 ☐			4   Indising Ho		ence 6 XOther		HOSPICE
no	te fie	ion	27. Manner of Death 1   Matural 5 □ Pend	ing (N tigation	ite of Injury fonth, Day Year)	28b. Time o Injury	Worl	Yes 2 No	28d. Describe II	low injury occurre	u	
Division	deatl ctor: y the	fica	3 Suicide 6 Could	not be 28e. Pl	ace of Injury - At h	ome, farm, si	reet, factory, office			treet and Number	r or Rura	l Route Number,
οį	s after I Dire	Serti	4 Homicide	bu	illding, etc. (Special	(y)			City or Tow	n, State)		
	To the Hospitel or Attendity within 24 hours after death.  To the Funerel Director: A completely filled in by the fu	Medical Certification:		I Exeminer: On th			th occurred at the time					
	Withir To 11 Comp	ž	29b. Signature and title of certif	De			29c. Licenso	number		29d. Date signed	(Month,	Day, Year)
	1			12			DL	3725		11/1	6/0	5
	5		30. Name and address of perso	n who completed c	ause of death (Iter	m 23a) (Type				. 7		
			DR. TARIQ MAE  31 Date filed (Month, Day, Yea		00 DULANI 2. Registrar's Signa	ature		TIMONIUM,	MD 210	93		
	Sta Regist	ate rar	NOV 2 2	0	Dies St	Spoon	(b)					

State of Maryland / Department of Health and Mental Hygiene 0 0 5 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** KATHERINS ALFINITO 0925 AM NOVEMBER 16 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Medical Colter If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6 Sex 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 200 F Days Yrs. 212-60-7489 JUNE 21, 1945 MARYLAND Director Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Show "natural", or Items 23s or 28s-f show 1 Pres 2 No Director BALTIMORE MD. 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 4130 STREET 31992 USA Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. and It item 27 is marked other than "natural", or Item ury or other traumatic event, Item Marked and ury or other traumatic event, Item Marked Exerciting 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Specify: þ Specify: 3 ₩idowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SCHOOL SYSTEM CITY CAFETERIA SERVICE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be SYLVESTER LOMBARDO JOHN JOSEPHINE T. ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 Is any injury or other trau once. MARGARET MORGAN, DAUGHTER 4/30 6+6 STREET BALTO. MD 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Fremation 3 ☐ Removal from State BAYVIEW CREMATORY 11-22-05 BALTO. MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility GONCE FUNERAL 21. Signature of Funeral Service Licensee 23a Part . Enter the dispass or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 4001 RITCHIE HWY BALTO MD 31772 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic preast caucer **Physician** /Medical Due to (or as a consequence of): Examiner Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (o as a consequence of) Examine physicien and s the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical use as i IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav 4□Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? 1 ☐ Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Cther: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury 1 Natural 5 Pending To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completely filled in by the fundamental Director. 1 ☐ Yes 2 ☐ No 2 ☐ Accident investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DS6399 ATTENDING 11/16/05 30. Name a laddress of perion who completed cause of death (Item 23a) (Type, Print)

.I.N. + AUAN MD 301 ST. Rown ST. Baltinere, all J.NAZARIAN, MO 32 Aegistrar's Signature 31. Date filed (Month, Day, Year) State NOV 2 2 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 05 Reg. No. U Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** REHABIL If Under 24 Hrs Birthplace (State or Foreign
 Country) 7. Age (In yrs. last birthday **Funeral** Hours Months Days 1**X**M 2□F Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Od. Inside City Limits 10b. County 10c. City, Town or Location 10a. State or Items 23e or 28e-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatih and Mental Hygiene. Important: If item 27 is marked other than "netural", or items 23e or 28e-1 show any injury or other traumetic event, If a Modical Examiner must be retified at 1 Syes 2 No MDby Funerai Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ €0 Specify: 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life DO NOT usp retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) othobyy (0-12) 18. Mother's Name (First, Middle, Maiden Surname, Father's Name (First, Middle, Last) 19b. Mailing Address (Street and Number al Route Number, City or Town, State, Zip Code) BaltOMD21218 hadened Mona Addison Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place, Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) emete 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dyl shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician /Medical Due to (or as a consequence of): **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Completed by Physician/Medical Examiner enoing physician and use as the burial-transit The law requires that the death certificate be executed LITUS TYPE 2 P.O. Box 68760, ed by the attending detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown signed by the signed of the si Part II. Dither significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1 Yes 2 No 1 Yes 2 🗌 No Division of Vital To the Hospital or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 1 ☐ Yes 2 No 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural Injury 5 Pending 2 🗆 No 1 Tyes within 24 hours after death. To the Funerel Director: A investigation Accident the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 1 4 Homicide 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year,

DHMH 17 Rev 1/2001

**ORIGINAL** 

LOCH

3900

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1-Certificate of Death Reg. No. 2. Date of Death ent's Name (First, Middle, Last) November 1 **Physician** 16 2005 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, **Examiner** RIVERSIde If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (la yrs. last birthday) 6. Sex **Funeral** Hours JONA Carolin Months Days 1 □ M 2 F 2-5815 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10h County 10a. State ortent: If item 27 is marked other than "natural", or items 23a or 28e-1 show injury or other traumatic event, the Mactical Examination and be notified at 1 Tes 2 No To Be Completed by Funeral Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status □ Never Married 2□ Married Maryland 21215-0036 1 □ Yes 2 □ Specify. 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Sumame) Name (First, Middle, Last Pages 1 and 2 should be nent of Health and Mental out: If item 27 Is marked o 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Importent: If item 27 Is any injury or other trat once. hod of Disposition ☐Burial 2 ☐ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Mydeardiot **Physician** /Medical Due to (or as a consequence of): Examiner Pan Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit prehorvasorla year Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No jo 4☐Pregnant at time of death 5 Other (specify) P.0. the 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has 1 ☐ Yes 2 No To the Hospital or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 2 NO 5 ☐ Residence 6 ☐ Other (Specify) 70 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28h Time of After t Certification: Natural 2 Accident 5 Pending investigation 2 No 1 ☐ Yes death. Director: 6 ☐ Could not be 3 🔲 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours after To the Funerel Direct 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State
Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

	. FOI	a,PIT 27, perME (851,1/17/ State of Maryland / Dep		Mental Hygien	enns 37541
V	1 - State Registrar		rtificate of Death	Reg. N	
Physician	1. Decement's Name (First, Middle, La	Adkins		Month D	3. Time of Death 16 2005 2:03 A
/Medical Examiner	4a. Facility Name (If not institution, giv		4b. City, Town, or Location of Dea		c. County of Death
		ton Medical Center	Glen Burnie		Anne Arundel
Funeral Director	5. Social Security Number  18-64-7864  Usual Residence of Decedent	7. Age (In yrs. last birthday, Yrs.	If Under 1 Year   If Under 24 Hrs   Months   Days   Hours   Min		9. Birthplace (State or Foreign Country)  Maryland
ith the Maryland or 28a-f show is notified.	10a. State 10b. County	10c. City, Town or L	coation Him of the coation		10d. fnside City Limits 1 ☐ es 2 ☐ No
Site death with the Mar ritems 23a or 28a-1 ei niner must be notified Funeral Director	10e. Street and Number	no Road	101. Zip Code 21239	10g. C	itizen of What Country?
O3(		1 ☐ Yes 2 ☐ No	Was Decedent of Hispanic Origin? (: If Yes, specify Cuban, Mexican, Puel 1 ☐ Yes 2 No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black
21215-0 ed within 72 ho ygiene ner than "natur. it, the Madical.	15. Decedent's E (Specify only highest gri Elementary/Secondary (0-12)	ade completed) (Give	edent's Usual Occupation a kind of work done during most of wo DO NOTuse retired)	orking 16b.	Sind of Business/Industry  On Structure
Maryland 2121 Into and Mahall Hygiene. Into and Mahall Hygiene. Z7 is marked other than r traumatic event, the Maryland To Be Comp	17. Father's Name (First, Middle, Last	Kins Sr	18. Mother's Na	me (First, Middle, Maide	on Sumame)
Ma olitha 27 is r trai	19a. Informant's Name/Relationship ( Tuan la D. A.  20a. Method of Disposition	Type, Print)  19b. Mail  19b. Mail  20b. Place of Disp	ing Address (Street and Number or Find Street and Number of Street and Number o	Rel Ba	Cookin, State, Zip Code)  Cho MD 21239  Location - City or Town, State
Baltimore, permit. Pages 1 ar Department of Hea Important: If Item any injury or othe once.	1 Burial 2 Cremation 3 Donation 5 Other (Special	Removal from State M cemetery, cre	emetory or other place)	23/05 P	alto MD
Balt permit. Depart Import any inji	21. Signature of Funeral Service Lice	Sui	4905 60 LD L	d. Bulk	TEL Seroias
Physician	shock, or heart failure. List only Immediate Cause (Final disease or condition	optications that caused the death. Do not en one cause on each line.  Myocarditis	nter the mode of dyfing, such as cardia ,	ic or respiratory arrest,	Approximate Interval Between Onset and Death
/Medical Examiner	resulting in death)	Due to (or as a consequence of):			
executed on and rial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):			
58760, icate be executed physicien and s the burial-transit	that initiated events 'resulting in death) Last	Due to (or as a consequence of):			
Box 68 sath certifica ettending pt for use as it	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetaf death 3	□Ectopic pregnancy		23d. Date of delivery
P.O. Box 6i hat the death certific d by the ettending p setached for use as Physician/Met	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		Other (specify)		Month Day Year
Cords, P.O. Box 6 w requires that the death certific been signed by the eltending p should be detached for use as		contributing to death but not resulting in the of unknown orgin, sarcoi	. •	23e. Did tobacco	ouse contribute to the cause of death?  2 No 3 Probably 4 Unknown
Division of Vital Records, P.O. Box 68 or attending Physician: The law requires that the death certificate death death.  Director: After this certificate has been signed by the ettending point by the tuneral director, page 2 should be detached for use as an ertification: To Be Completed by Physician/Mec				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of each?  Yes 2□ No
/ital			26. Place of De	eath (Check only one)	
ohysic this co	TXTXYes 2 □ No	Hospital: 1 Inpatient 2XXPR/Outpatie		Home 5 Residence	
Division cells or attending Presents after death. el Director: After ted in by the tuners certification:	27. Manner of Death  1 Natural 5 Pending 2 Accident vestigation 3 Suicide 6 Could not		of 28c. Injury at Work?  M 1 Yes 2 No	28d. Describe how in	
Divine a steer or ret Diri			treet, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
he Hospi in 24 hour he Funer pletely fill edical	29a. Certifier 1 ☐ Certifying P (Check only XX Medical Exa	hysician: To the best of my knowledge, dea miner: On the basis of examination and/or in and manner stated.			
To the To the company	29b. Signature and title of certifier	as Al	29c. License number  OCME		pate signed (Month, Day, Year) rember 16, 2005
	30. Narpa and address of person who	completed cause of death (Item 23a) (Type	, Print)		Maryland 21201
State	31. Date filed (Month, Day, Year)	32. Registrar's Signature	TIT TEIM DUTGER	. DOTUMOTE,	THE YEAR 21201
Registrar	NUVAAZ	005 Jan 15 1	park		

OPIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amend item#7, per DVR, G849, 11-23-05 TI

State of Maryland / Department of Health and Mental Hygiene Reg. No. 005 Certificate of Death 3. Time of Death 2. Date of Deeth 1. Decedent's Name (First, Middle, Last) Physician IAN TIME 2001 11 /Medical City, Town, or Location of Death 4c. County of Death 4a Fecility Neme (If not institution, give street end number) Examiner BALTIMORE BALTIMONE LONG GREEN 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1□ M 2⊡ F Yrs. 7 40 0000 Director Μđ Usual Residence of Decedent Pages 1 end 2 should be filed within 72 hours after death with the Marylend nent of Health end Mantel Hygiana. 10d. Inside City Limits 10a. Stete 10b. County 10c. City, Town or Location No Yes 2 □ No Baltimore Md. NA Director r than "natural", or items 23s or 28s-f the Medical Examiner must be notified 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral 1000 Woodson Road Apt. H

Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 21212 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 Yes 2 No If Yes, Give X Year or Dates: 1 Never Merried 2 Married 1 ☐ Yes 2 X No Specify: Baltimore, Maryland 21215-0020 Specify: þ Black 3 ☐ Widowed 4 ♥ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondery (0-12) College (1-4or 5+) Hygiana. Post Office Clerk 12th grade 17. Father's Neme (First, Middle, Lest) 3 Yrs 18. Mother's Name (First, Middle, Maiden Surname) Be Maddox Gattis Serena Winfield 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) item 27 l 1000 Woodson Rd. Apt. H, Baltimore, Md. Adetokumbo Adeyinka Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department of Important: If it any injury or o 11-23-05 Arbutus , Md. Arbutus Mem. Park 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Baltimore, Md. March F.H. East 1101 E. North Ave. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician Immediate Cause (Final distrase or condition resulting in death) /Medical Examiner Physician/Medical Examiner Hospital or Attending Physician: The law requiras that tha death certificeta be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury attanding physician and Division of Vital Records, P.O. Box 68760, resulting in death) Last 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 | Yes 2 | No 3 | Probably 4 TUnknown Completed by 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No : After this certifice e funeral director, p Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 1 Natural 5 Pending investigation To the Hospital or Attending within 24 hours aftar death.
To the Funeral Diractor: Afte completely filled in by the fun 1 ☐ Yes 2 ☐ No 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner steted. 29a. Certifier edicai (Check only 29d. Date signed (Month, Dey, Yeer) 29b. Signature end title of certifier 30. Name and address of person who completed ceuse of death (Item 23e) (Type, Print) Du 01 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

DHMH 16 Rev 6/95

			For State	State of Ma	-	artment of F		nd Mental Hyg	711	05	37543
2	Physici		Registrar     Decedent's Name (First, Middle, Las	Peter	Edward	Brown	Douin	2. Date of Dea Month	ath Day	Year 2005	3. Time of Death
),	/Medio Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	or Location of C	Death	4c. Count	y of Death	1110
13.	Funeral Director		219-44-0992	7. Age	(In yrs. last birthday 59 Yrs.	Months Days	If Under 24 Hours	Hrs. 8. Date of Birth (Month, Day 18)	/, Year)	Cour	place (State or Foreign ntry) yland
	Maryland	tor	Usual Residence of Decedent  10a. State 10b. County  MD Ba	1timore	10c. City, Town or L		tonsv	ille Mand	or	1	10d. Inside City Limits
	or 28a	Director	10e. Street and Number	_		10f. Zip Code			10g. Citizen of		ntry?
3036	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. I Health and Mental Hygiene. Item 27 is marked other than "natural", or Iteme 23s or 28s-f show other traumatic event, the Madical Examinar must be notified.	by Funeral	5943 Baltimor  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	e Street  12. Was Decedent E Armed Forces?  1 □ Yes 2 ▼ N If Yes, Give Year or Dates:	ever in U.S. 13.	Was Decedent of HI Yes, specify Cub		n? (Specify Yes or No- Puerto Rican, etc.)		USA ce - Americ ack, White, ify: Wh	
1215-0036	within 72 h iene. than "natu	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5-	(Give	dent's Usual Occup a kind of work done DO NOT use retire Machinis	during most o d)	f working	16b. Kind of E		
Maryland 21	be filed ital Hygie d other	Be	17. Father's Name (First, Middle, Last)					Name (First, Middle,	<del></del>		
ıryla	should land Menits marke	ဥ	Edward F  19a. Informant's Name/Relationship (7	rancis	Brown 19b. Mail	ing Address (Street		ara Vi	rgini		Zachman
_	s 1 and 2 s if Health ar item 27 ts other trau		Shirley A. Brown 20a. Method of Disposition	, wife	5943	Baltim	ore S	t. Catons		Manor	, MD 2120
altimore,	Pages ment of lant: If it		1 Burial 2 Cremation 3 4 Donation 5 Other (Specify		Metro Cre	matory,	Inc. 11				e, MD
Balt	permit. Pages Department of Important: If it ony injury or o		23a. Part1. Enter the disease, or comp	acNabb lications that caused	the death. Do not en	99 Fred	erick		ltimo	nd, re,	MD 21228 Approximate
) 	Physician /Medical Examiner		shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	a. Aux Due to (or as a	a consequence of):	atory Dis.	1893	Syndrone			Interval Between Onset and Death 12 hrs
8760, /×	The law requires that the death certificate be executed ate has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	dicai Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Congre	a consequence of):  Shve Hea a consequence of):	art Fail	live				71045
P.O. Box 6	<ul> <li>requires that the death certific</li> <li>been signed by the attending f</li> <li>should be detached for use as</li> </ul>	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	□Ectopic pregnanc □ Other (specify) _	у			ate of deliver	ery Day Year
S,	es that igned b	by Pt	Part II. Other significant conditions of	i	-	underlying cause giv	ven in Part I.				he cause of death?
Records,	has been s	Completed	Diabeles Mel	y disease Hhis	2			24a. Was a autop	sy	prior to co	pably 4 Unknown
Vital F	iclen: The certificete ector, pag	e Cor	25. Was case referred to medical				36 Place of	perfor 1 ☐ Yes f Death (Check only or	2)XN0	death?	200 No
<u> </u>	Physicle this cert al direct	To B	examiner? 1 ☐ Yes 2,5 No	Hospital: Hopatier			ner: 4 ☐ Nursi	ng Home 5 Resid		her (Specif	y)
Division of		Certification;	27. Manner of Death  The Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	28a. Date of Injur (Month, Day		M 1	ryat rk? ]Yes 2 □ No				
DIA	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer		4 Homicide determined	building, etc				City or Tow	in, State)		al Route Number,
	To the Hospitel or within 24 hours after To the Funeral Dir completely filled in I	Medical	29a. Certifier (Check only one) 2 Medical Exam	rsician: To the best of iner: On the basis of and manner sta	examination and/or in	th occurred at the ti nvestigation, in my o	me, date and popinion, death	place, and due to the o occurred at the time, o	ause(s) and m date and place,	anner as s , and due to	tated. the cause(s)
)	To the within	W	29b. Signature and title of certifier		MO	29c. Licens		1	Pov S		
2	10		30. Name and address of person who de land address of person	nder, M.I.	path (Item 23a) (Type	Print) Ton Mem	onal L	46 lospital,	MD		
	Sta	ne						Ť			

ORIGINAL

DHMH 17 Rev 1/2001

Registrar

NOV 2 2 2005

				1 - For State Registrar	State o	f Marylar		artment of F	lealth and N Death		giene 0 0 5	37544
		*	- A	Decedent's Name (First, Middle, La	ıst)					2. Date of De	ath	3. Time of Death
		Physici /Medic		Marvin Wayne Bak	er					November 1	Pay Year 21, 2005	7:34 A M
		Examin		4a. Facility Name (If not institution, give				_	r Location of Death		4c. County of Dea	
		Щ		Gilchrist Center  5. Social Security Number 6.5	For Hos	PICE  7. Age (In yrs.	lant historia.	'I'OV If Under 1 Year	VSON If Under 24 Hrs.	P. Data of Bird	Baltin	
	\$. **	Funeral Director			10XM 2□F	62	Yrs.	Months Days	Hours Min.	8. Date of Birt (Month, Da	11,1943 Ma:	rthplace (State or Foreign ountry) rvI and
	196			Usual Residence of Decedent				1		August	11,1545	Lylana
		arylan show	_	10a. State 10b. County		10c. Cit	y, Town or Lo					10d. Inside City Limits
		the Mar 28a-f sh	Director	Maryland Baltimo	re		Essex			1		1 ☐ Yes 2X No
		within 72 hours after death with the Maryland ene. than "netural", or iteme 23a or 28a-f show than "netural", or items the notified at		1946 Sue Creek D	rive			10f. Zip Code 21	221		10g. Citizen of What C USA	ountry?
		tome	Funerai	11. Marital Status	Armed Fo			Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecrfy Yes or No Rican, etc.)	14. Race - Am Black, Wh	
	36	rs afte	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ⊠Yes If Yes, Gir Year or D	2 No ve		1□ Yes 2⊠ No	Specify:		Specify: W	hite
	21215-0036	2 hou		15. Decedent's E	ducation		16a. Dece	dent's Usual Occup	ation		16b. Kind of Business	s/Industry
	215	thin 7:	Completed	(Specify only highest gr Elementary/Secondary (0-12)	a <i>de completed)</i> College (1	1-4or 5+)	life.	DO NOT use retired		king	G+1 M:11	
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5	and	bd at a	Be	17. Father's Name (First, Middle, Lass Charles Raymond					18. Mother's Nam Helen Fl		Maiden Sumame) Rasili	
:34 AM	Maryland	d 2 should be fi in and Mental H 7 is marked of treumatic ever	၉	19a. Informant's Name/Relationship			19h Mailir	on Address (Street			er, City or Town, State,	Zin Code)
I	Ma	and 2 s ealth an n 27 is ner treu		Judith Ann Baker							e, Md. 2122	
9.1	re,	T E E		20a. Method of Disposition			Place of Dispo	sition (Name of matory or other place	20)	Date	20c. Location - City o	Town, State
7	altimore,	Page nent o ant: ff ary or		1		State Ho.	lly Hil	ll Mem. Ga	rdens 11/	26/2005	Baltimore,	Maryland
B	Balt	permit Pag Department Importent: f any injury o		21. Signature of Funeral Service Lice	nses)	7	l B	Name and Addre	ki Funera	l Home_I	P.A.	4554
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	d A	Physician		Immediate Cause (Final		Pistati	: 14	icr a	ance			Interval Between Onset and Death
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G:	1	Examiner		Sequentially list conditions,		6<6k		edder c	ancu			in out the
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a	XOX	death certificate be executed e attending physician and od for use as the burial-transi	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	tcome of pregna	ancy Il death 3 [	Ectopic pregnancy	,		23d. Date of de	•
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2	Ρ.	that the di ed by the detached	Ph	Part II. Other significant conditions	contributing to d	eath but not res	ulting in the u	nderlying cause giv	en in Part I	23e. Did to	bacco use contribute t	o the cause of death?
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WYIN	Re	The larate has	mo					· · · · · · · · · · · · · · · · · · ·		autop perfo 1 ☐ Yes	rmed? prior to death?	completion of cause of s 2 □ No
3	ita		Bec	25. Was case referred to medical examiner?	emero.				26. Place of Deal			2 2 140
2	of <	Physicien: this certific ral director,	70	1 ☐ Yes 2 🚉 No			ER/Outpatier		4   Mulaling Inc	ome 5 Resid	lence 6 Other (Spe	ecity)NCXIQ
_		D 0 0	lon:	27. Manner of Death  1 Natural 5 Pending		of Injury th, Day Year)	28b. Time of Injury	Wor		28d. Describe h	low injury occurred	
9	ision	death ctor: y the	licat	2 Accident investigation 3 Suicide 6 Could not t		of Injury - At h	ome farm str		Yes 2 No	28f. Location (5	Street and Number or F	lural Route Number
8	Ď	after Dire	Certification;	4  Homicide determined	buildi	ing, etc. (Specii	y)	eet, factory, office		City or Tox		ara ricate rearibor,
9		To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the fune	edical C	29a Certifier Certifying P	hysician: To the	a bast of my kno	wladga 3sat	cocumed at the ti	ins, date and place	and due to the	date and place, and du	s stated.
		the H hin 24 the F nplete	Medi	one)	and man	ner stated.						
		To To Con		29b. Signature and title of certifier	w			29c. Licens	8503	,	November 2	th, Day, Year)
		1041		30. Name and address of person who	completed caus	_ /	n 23a) (Type,	Print) ( Lou (	L St	2005	November 2	12x4
		Sta		31. Date filed (Month, Day, Year)	100	Registrar's Signa	ature					I
	100	Registr	ar	NOV 2 2 200	5 Mass	13.0 A.S.	A CONTRACTOR OF THE PARTY OF TH	Mark .				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Nov. 18 2005 Year **Physician** Concetta C. Bowler 1:45a м /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner EastpointRehab&NursingCenter Baltimore Baltimore 8. Date of Birth (Month, Day Year) May 14, 1927 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign 1 ☐ M 2 ☐ X Days Hours Min. 220-18-5286 78 Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 17 is marked other than "naturel", or Itama 23a or 28a-f show traumatic event, it a Meulcul Examiner must be notified at 10d. Inside City Limits MD Baltimore Baltimore Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2825 Lodge Farm Road 21219 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: Specify: White permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If Itam 27 Is marked other than "naturel", vany injury or other traumatic event, its Medical Expanse. Completed by 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home 7th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Belcastro Rose Ferarri 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia McHale /daughter 2479 Lewis Lane Finksburg MD 21048 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other of 20c. Location - City or Town, State 1 

Burial 2 □ Cremation 3 □ Removal from State SacredHeartofJesus 11/21/05 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility ConnellyFuneralHomeofEssex 21. Signature of Funeral Service Licensee 300 Mace Ave. Baltimore MD 21221 23a. Part1. Enter the disease, or complications that caused the death. Shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) ADVANCED EMPHYSEMA **Physician** /Medical Examiner Societisly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy Month 4☐Pregnant at time of death Day Year 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? should I 4 Donknown 1 Yes 2 No 3 Probably 24b. Were aulopsy findings available prior to completion of cause of death? certificate has tirector, page 2 s 24a. Was an autopsy performed? 1 ☐ Yes 2 NO or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Other: Nursing Home 5 Residence 6 Other (Specify) Medical CertIfication: To 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA 1 Inpalient this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending Injury death. ours after death.

neral Director: A
filled in by the fu 1 Tyes 2 No 2 Accident investigation 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a
To the Funeral C
completely filled Critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D005845 NOVEMBER 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WAVA CEASAR LOCK RAVEN SOULDUMED , GARTIMURE 5601 MORRIS 31. Date filed (Month, Day, Year) 2. Registrar's Signature State WW 2 2 2005 GONE ! Registrar

State of Maryland / Department of Health and Mental Hygiene 1 1 5

			State of Maryland / E	Certificate of Death		g. No.	3/346
			Decedent's Neme (First, Middle, Lest)	0 2.10	2. Date of Deeth		3. Time of Death
	Physici /Medic		ROBERT R.	BOND	Novembe	Dey Year	
20	Examin		4a Fecility Neme (If not institution, give street end number)	n	r Locetion of Death	4c. County of Dea	
Ľ			Keswick multicare center	BAUTA			I/A
	Funeral Director		133 10 3073	rrs. If Under 1 Year If Under 24 Hi Months Days Hours Mi		,1923 New	othplace (State or Foreign Sountry) Orleans, LA.
	pue & =		Usuel Residence of Decedent           10a. State         10b. County         10c. City, Town	or Location			10d. Inside City Limits
	Mary First	ţŏ	Maryland Baltimore County Balti	more			1 ☐ Yes 2℃No
	h the	Irec	10e. Street end Number	10f. Zip Code	100	g. Citizen of What C	ountry?
	th wit	Funeral Director	907 East Wind Road	21204		United	States
	r dea	Jue	11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces?	13. Was Decedent of Hispanic Origin?	Specify Yes or No-	14. Race - Ame Black, Whi	erican Indian,
0020	be filed within 72 hours efter death with the Marylend ital Hygiene. Id other then "natural", or items 23a or 28a-f show event, the Medical Examinar must be nortified at	þ	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: ₩.₩. I ☐	1 ☐ Yes 2 🖺 No Specify:			White
5	natu natu	Completed	15. Decedent's Education 16e. (Specify only highest grede completed)	Decedent's Usual Occupetion (Give kind of work done during most of w life. DO NOT use retired)	orking 16	6b. Kind of Business	/industry
12	withir ene. than	m.	Elementery/Secondary (0-12)   College (1-4or 5+)	Vice President		:1 • PT	
9		Be Cc	17. Fether's Neme (First, Middle, Lest)		ame (First, Middle, Ma		<u>ational Bank</u>
lan	should be filed withind Mental Hygiene. marked other than	OB	Walter Edmund Bond	Helena	Wessinger		
an	2 shot N end N is main		19a. Informant's Name/Relationship (Type, Print) 19b.	Mailing Address (Street and Number or F	Rurel Route Number, (	City or Town, State,	Zip Code)
Σ,	end salth 27			7 East Wind Road Ba	altimore, h	Maryland	21204
Baltimore, Maryland 21215-0020				Disposition (Name of r, crematory or other place) Funeral Chapel	NOV.	Oc. Location - City or	rtown, State 11, Maryland
Balti	permit. Pages Depertment of Important: If it eny injury or o		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Peaceful Alternati	ives Funera	al&Cremat:	ion Ctr.P.A.
	*,	$\dashv$	23a. Part. Enter the disease or complications that caused the death. Do no shoot or hear failure. List only one cause on each line.		Linonium, Ma ac or respiratory arrest		21093 Approximate
e of	Physician		shoot or pear tailure. We conly one cause on eech line.				Interval Between Onset and Death
	/Medical		Immediate Cause (Final disease or condition resulting in death)  e.   asproach  e	preumonia			LAUS
	Examiner	_	resulting in death)  Due to (or as a co				
	ted nsit	nine	b				
Ć	tificete be executed g physician end es the bunal-transit	Examiner	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury	onsequence of):			
68760,	ste be nysicia ne bur	edical	Ceuse (Disease or injury that initieted events resulting in death) Lest    C. Due to (or as a co	onsequence of):			
39 X	certifice iding ph ise es t	5 I	d.				
Box	death cer a attendir d for use	Physician/	Part II. Other significant conditions contributing to death but not resulting in	the underlying source given in Bort I	22h Didtaha		e to the cause of death?
P.O.	t the c by the teche	hys			23b. Did toba	. 1	robably 4 Unknown
	es the igned be de	Š	Parkinson durase, Colon Car	ver, colectorne	1	7	
of Vital Records,		Completed			24a. Was an a performe	ed? ' 1	Were autopsy findings available prior to completion of cause of death?
æ	m _ = =	E			1 ☐ Yes	2 110	1 ☐ Yes 2 ☐ No
/ita	ician: The certificete rector, pag	Be	25. Was case referred to medical examiner?	26. Place of De	eath (Check only one)		
<u></u>	hysic this ce el dire	ို	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outp	1	Home 5 ☐ Residenc	e 6 □Other (Spe	cify)
u C	Ing P	<u>ë</u>	The factor of th	jury Work?	28d. Describe how	injury occurred	
Division	Attending Physician: or death. ector: After this certific by the funeral director,	Icat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farr	M 1 Yes 2 No	28f Location (Street	et and Number or Ru	um I Route Number
á	el or Attending P s efter death. il Director: After t ad in by the funers	Certification:	4 Homicide determined 286. Place of Injury - At nome, fair building, etc. (Specify)	n, street, factory, emoc	City or Town, S		ara mode ramber,
	To the Hospital or Attending Physician: within 24 hours effer death.  To the Funeral Director: After this certific completely filled in by the funeral director,	edicai	29a. Certifier (Check only one) **Descripting Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and/and manner stated.	death occurred at the time, date and plac for investigation, in my opinion, death occ	e, and due to the caus urred at the time, date	se(s) and manner as and place, and due	s stated. e to the cause(s)
-	To th To th comp	Z	29b. Signature and title of certifier	29c. License number		Date signed (Monti	
	. \		African (m)	D 58303	,	rember	20 2005
	WX 2		30. Name and address of person who completed cause of death (Item 23e) (T	Charles ST To	Jan, ma	2120	4
	Stat		31. Date filed (Month, Day, Yeer)  NOV 2 2 2005  Registrar's Signature	Carle			(
	Registra	r	MOV 2 2 2000				

DHMH 16 Rev 6/95

			1- State of N Registrar		ertment of Health and I ertificate of Death		2000	37547
	Physic	ian	Decedent's Name (First, Middle, Last)		· A I I I	2. Date of Death Month	No.  Day Year	3. Time of Death
	/Medi	cal	Harold Thomas  4a. Facility Name (If not institution, give street and number	-) .	Blanchard  4b. CityaTown, or Location of Death	November	r 20,20	22:05 M
	Examir	ier	The Johns Hopkins to	059:491	104/times	5	4c. County of Dea	atn
	Funeral Director		220-54-602 10M 20F	ge (In yrs. last birthday 55 Yrs.	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth (Month, Day, Ye	9. Bi	rthplace (State or Foreign Country)
	yland		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or L	ocation			10d. Inside City Limit
	he Mar 8a-fal	Director	mo Bartimore	TIMO	noum			1 ☐ Yes 2 No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23e or 28e-1 ahow any injury or other traumetic evant, tra Medical Exertified at anote.	al Dire	36 Flank Ave.		10f. Zip Code 2/093	10g.	Citizen of What C	Country?
	ter dea	Funeral	11. Marital Status  12. Was Deceden Armed Forces  1 □ Never Married 2 ☑ Married  1 ☑ Yes 2 □	Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Silf Yes, specify Cuban, Mexican, Puert	pecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	erican Indian, ite, etc.
21215-0036	iral', or	Ď	3 Widowed 4 Divorced If Yes, Give Year or Dates		1 ☐ Yes 2 ☑ No Specify:		Specify:	hite
15-(	in 72 h "natu Ivile	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	edent's Usual Occupation e kind of work done during most of work DO NOT use retired)	king 16b	. Kind of Business	s/Industry
212	filed with Hygiene. other than	Comp	Elementary/Secondary (0-12) College (1-4or	5+) Cr	edit manage	r	1edia	al Supplies
and	d be fill ental Hy sed oth	Be	17. Father's Name (First, Middle, Last)	nha :-1	18. Mother's Nam	ne (First, Middle, Maid	ten Surname)	1
Maryland	2 should to and Ment la marked aumetic e	2	19a. Informant's Name/Relationship (Type, Print)	Wife 19b. Maili	ing Address (Street and Number or Bu	ral Route Number, Cit	ty or Town, State,	Zip Code)
	1 and 2 Health em 27 I		Mrs. Marie Blancha	20b. Place of Dispo	Evans he.	11 moni	um, mi	121093
Baltimore,	permit. Pages 1 a Department of Hes Important: If item any injury or otha once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  4 ☐ Donation 5 ☐ Other (Specify)		matory or other place)	23 /05. F	Location - City or	Town, State
3alti	permit. F Departme Importar any injur		21. Signature of Funeral Service Licensee	- 000/13	2. Name and Address of Facility	KRD. Til	new war	MD 21093.
	70 F # 0		23a. Part 1. Enter the disease, or complications that cause	the death. Do not en	CHUEFUL HUZIIUMI	YES FUNCE!	A CREP	APPROX CAVIER
	Physician		23a. Part1. Enter the disease, or comblications that cause shock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition	he. ardiovas	1 / 11	or respiratory arrest,		Interval Between Onset and Death
	/Medical Examiner		resulting in death)	a consequence of):	enjar collap	16		D honrs
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	eTabolic a consequence of):	teidosis			12 hours
_	xecuter and il-transi	Examiner	Cause (Disease or injury that initiated events	a consequence of):	schemia			24 hours
68760	ificate be executed g physician and as the burial-transit	edical E	d. Ba	wel 1	Obstraction			24 hours
	entifica ding ph	/Med	IF FEMALE:					
. Bo	The law requires that the death certiste has been signed by the attending bage 2 should be detached for use a	Physiclan/M	1 Ves 2 No. 4 Pregnant a	2 Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of del Month	livery Day Year
P. O.	that the de led by the a detached t	Phys	9 Unknown  Part II, Other significant conditions contributing to death I	100				
Vital Records,	quires t n signe	Completed by	Liver fallure, sepsi	S Pena	Pattuce			the cause of death?
eco	law require las been signal 2 should b	plete				24a. Was an autopsy	24b. Were au	utopsy findings available
		е Соп	06 W			performed?	death?	completion of cause of
	> 0 D	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Impati	ent 2 ER/Outpatien	O+	me 5 Residence	6 □Other (Soe	cutu)
	ing Affei une	on;	27. Manner of Death 1 Pending 28a. Date of Inju (Month, Da	y Year) 28b. Time of Injury	f 28c. Injury at Work?	28d. Describe how in		5.19)
DIVISION	of or Attending after death. I Director: After I in by the fune	Certificat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of In building e	ury - At home, farm, str	M 1 ☐ Yes 2 ☐ No reet, factory, office	28f. Location (Street	and Number or Ru	ural Route Number,
5	pitel or ours afte aral Dir illed in			c. (Specify)		City or Town, Sta	ŕ	
	To the Hospitel or A within 24 hours after To the Funaral Directompletely filled in by	edical	29a. Certifier (Check only one)  1 Certifying Physician: To the best 2 Medical Examiner: On the basis of and manner st	i examination and/or inv	h occurred at the time, date and place, vestigation, in my opinion, death occurr	and due to the cause( ed at the time, date a	(s) and manner as nd place, and due	stated. to the cause(s)
	To t	2	29b. Signature and title of certifier		29c. License number	29d. D	Date signed (Month	h, Day, Year)
1	2		30. Name and address of person who completed cause of c	eath (Item 23a) (Type	KES-000	No	sember	20 2005
	· ·		30. Name and address of person who completed cause of a San tosh Commen 600 31. Date filed (Month, Day, Year) 32. Rights	North U	Golfe Street, Bo	Himore	Maryl	land 21287
	Sta Registra	te ar	NOV 2 2 2005	ars Signature	Carte		-	

State of Maryland / Department of Health and Mental Hygien [ 37548 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 4:20 A.M Evelvn G. Bock November 17, 2005 /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Wesley Home Baltimore If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Funeral Days 1 ☐ M 2 🕮 F 216-14-0952 Director 15. 1908 Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County 28e-f show f Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28e-f shov other treumatic event, the Madical Examprant must be notified at 177 Yes 2 □ No Baltimore Director Maryland 10f. Zin Code 10g. Citizen of What Country? 10e. Street and Number 2311 West Rodgers Avenue 21209 USA 2 should be filed within 72 hours after death and Mental Hygiene. Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ormit. Pages 1 and 2 should be.
Department of Health and Merlingorient: if the Z7 transportants or cr. William Leopold Mary Estelle Hales ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Phyllis S. Lary 3492 Spear Street; Charlotte, Vermont Cousin 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 11/21/2005 Baltimore, Maryland 22. Name and Address of Facility
Witzke Funeral Home of Catonsville, Inc 21. Signature of Europeal Service License 1630 Edmondson Avenue; Catonsville, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Stage Dementia **Physician** /Medical **Examiner** A Denoscleven Vas cular Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical the attending p for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ pe 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed 2 No 1 Yes 2/2 No 1 Yes certificate Hospitel or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 virsing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical (Check only one) within 2 To the the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2 11-18-05 D21464 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD. 3508 BANG 32. Rainar's Signature 31. Date filed (Month Day, Year) State Registrar

			For State Registrar		State of Ma	aryland	d / Depa <i>Ce</i>	artment <i>rtificate</i>	of He	ealth a Death	and Ment	tal Hygier	and the state of the	37549
	Physic /Medi		1. Decedent's Nam	e (First, Middle, Las	JANIC	E M.	BOSI	EY			N	ate of Death	ay Year	3. Time of Death
	Exami Funeral Director	ner		10	NURSIN		OME ast birthday) Yrs.	If Under 1	ITS	BURG If Under 2 Hours	24 Hrs. 8. D. Min. (A	ate of Birth fonth, Day, Yea	FREDER  9. Bir	ICK thplace (State or Foreign ountry)
	p ,		Usual Residence of 10a. State	7201			, Town or Lo	ocation			MAY	7 6, 19	927 WES	T VIRGINIA  10d. Inside City Limits
	death with the Maryland ms 23a or 28e-f show rmust be notified at	Director	MD	CARROLI	<u>,                                     </u>		WESTM	INST			51			1 □ Yes 2 No
	ath with		9.00	BACHMA	N VALLEY	RD.		10f. Zip 0	158				Citizen of What Co	ountry?
5-0036	ours after de rel', or Items Exerciper	by Funeral	11. Marital Status 1 ☐ Never Marri 3 ☐ Widowed	ied 2□ Married	12. Was Decedent   Armed Forces? 1 ☐ Yes 2 ↑ If Yes, Give Year or Dates:			Was Decede If Yes, specif 1 ☐ Yes 2	y Cuban	panic Orig , Mexican, Specify:	gin? (Specify Y , Puerto Rican	es or No- , etc.)	14. Race - Ame Black, Whit Specify: WH	te, etc.
21215-(	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatih and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or Items 23a or 28e-4 show any injury or other treumatic event. It Medical Exertinet must be natitied at an	Completed	(Specification) (Specification	15. Decedent's Edu ify only highest grad indary (0-12)	ucation de completed) College (1-4or 5	i+)	(Give life.	dent's Usual kind of work DO NOT use OT CAT	done du retired)	iring most			Kind of Business	/Industry
Maryland	uld be file fental Hy rked othe	To Be C	17. Father's Name	(First, Middle, Last) KAE	3LE		JOHNS	ON			r's Name <i>(Fir</i> s LILA	t, Middle, Maide		MOMN
	and 2 shoualth and Mark		19a. Informant's Na STEVE B	ame/Relationship (T)	*	ИС	19b. Mailir 5 0 8	OLD	Street ar	nd Number	r or Rural Rou	te Number, City	or Town, State, 2 WESTMI	Zip Code) 21158 NSTER, MD
Baltimore,	t. Pages 1 arment of He rtent: If iten njury or oth		20a. Method of Disp 1 Burial 23 4 Donation	Cremation 3 ☐F 5 ☐ Other (Specify)	Removal from State	20b. Pla ce	metery, crer COUNT	sition (Name natory or oth Y CRE	er place, MAT	ION		/05 SY	Location - City or KESVIL!	LE, MD.
Bal	permil Depar Impor any ir	W 9		Servic Lens			2.	54 E.	MA	IN S	T.,WE	STMINS	NERAL F	HOME D. 21157
	Physician /Medical		23a. Part T. Enter the shock, or heal Immediate Cause (disease or condition resulting in death)	e disease, or completailuge. List only of Final n	ne cause on each line.  Due to (or as a	» ا ره	Do not ent	er the mode	of dying,	such as c	cardiac or resp	iratory arrest,		Approximate Interval Between Onset and Death
<b>\</b>	Examiner	Examiner	Sequentially list contain, leading to make cause. Enter Under Cause (Disease or that initiated events	nditions, I	Due to (or as a	UNE-	To	THYCI	ve <sup>-</sup>					
58760,	cate be executed physician and the burial-transit	dlcal Exa	that initiated events resulting in death) L	ast	Due to (or as a	a conseque	ence of):							
.O. Box 6	The law requires that the death certifics 11e has been signed by the attending pt 2ge 2 should be detached for use as I	Physician/Med	IF FEMALE: 23b. Was decedent in the past 12 1  Yes 2  9  Unknown	months?	3c. If yes, outcome of 1  Live birth 4  Pregnant at 9  Unknown	2 Fetal o	leath 3□	Ectopic preg Other (spec					23d. Date of deli Month	ivery Day Year
ords, P	w requires that been signed k should be det	by	Part II. Other signifi	cant conditions cor	ntributing to death bu	t not result	ting in the ur	derlying cau	se given	in Part I.	23	3e. Did tobacco		the cause of death?
		Completed	25 W.									la. Was an autopsy performed? Yes 212 No	prior to death?	topsy findings available completion of cause of
	ding Phys h. After this funeral dii	tion: To Be	25. Was case referr examiner?  1 ☐ Yes 2 ☐  27. Manner of Death  1 ☐ Natural  2 ☐ Accident	K0	fospital: 1  Inpatier 28a. Date of Injun (Month, Day	/ 2	R/Outpatient 28b. Time of Injury		Other: Injury a Work?	4 Nurs	28d. De		6 ☐Other (Specing occurred	rify)
Division	lel or Attending s after death. el Director: After ed in by the fune	Certification;	3 Suicide 4 Homicide	6 Could not be determined	28e. Place of Injubulding, etc.	ry - At horr . (Specify)	ιθ, farm, stre	et, factory, o	ffice		28f. Lo	cation (Street ar y or Town, State	nd Number or Ru e)	ral Route Number,
	To the Hospitel within 24 hours a To the Funerel Completely filled in	edical	29a. Certifier (Check only one)	1 Certifying Phys 2 Medicel Exemin	sicien: To the best o ner: On the basis of and manner stat	examinatio	edge, death in and/or inv	occurred at estigation, in	the time, my opin	date and ion, death	place, and due occurred at the	e to the cause(s	) and manner as d place, and due	stated. to the cause(s)
	To the within 2 To the Complete	Σ	29b. Signature and	SIM				D	oo (	umber +7 9	15		te signed (Month	
3	) 4		SIBTE	A. KAZ	MI, HU	814	Tou	Hous		ve	FREDE	RICK -	MD	21701
	Sta Registr	ar	31. Date filed (Monti	NOV 2 2	32. Registral	rs Signatu	A. A.	poli	Î					
DHN	MH 17 Rev 1/20	001		4 17	D. Barrell									

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene	In	5	371	5
Cartificate of Dooth		13	OI	0

			For State Registrar	State of M	aryland /		irtment of H <i>tificate of L</i>			giene Reg. No.	005	37550
+	Physici		1. Decedent's Name (First, Middle, La RUDOLPH S		BROWN				2. Date of De Month NOVEMB		5 2005°	3. Time of Death 12:45 PM
	/Medic Examin	-	4a. Facility Name (If not institution, given MANOR CARE	e street and number)			4b. City, Town, or BALT IM	Location of Death		4c.	County of Death	1
	Funeral Director		213-22-3429	Sex 7.Ag ICXM 2□F	ge (In yrs. last 77	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	iy, Year)	9. Birthp Coun	lace (State or Foreign try)
	Maryland f ehow led at	tor	Usual Residence of Decedent  10a. State 10b. County  MD		10c. City, To	own or Lo					11	0d. Inside City Limits 1 XYes 2 □ No
	or 288-	irec	10e. Street and Number				10f. Zip Code			10g. Citi.	zen of What Coun	try?
	23a c	raiD	3310 THE ALAMED				2121			ŲS		
5-0036	72 hours after death with the Maryland "netural", or Items 23a or 28a-f show colcal Examinar must be notified at	by Funeral Director	11. Marital Status  1 ☑ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces  1	? No		Vas Decedent of Hi f Yes, specify Cuba I ☐ Yes 2 No	n, Mexican, Puerto	ecify Yes or No Rican, etc.)	)-	14. Race - Americ Black, White, ( Specify: B]	
5-0		Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	10	6a. Deced	lent's Usual Occupa kind of work done of OO NOT use retired	ation furing most of work	ing	16b. Kii	nd of Business/Inc	dustry
2121	within iene. then "	dwo	Elementary/Secondary (0-12)	College (1-4or			ITY OFFIC			HEA	ALTH	
d 2	if Hygin other	Be C	17. Father's Name (First, Middle, Last	)				18. Mother's Nam	e (First, Middle			
Maryland	should by	70 E	DAVID L. BROWN,	SR.				ANNI	E MAE (	UNKNO	OWN)	
Man	12 sho		19a. Informant's Name/Relationship	1000	1		g Address (Street a			-		
	1 and Health		EDITH JONES/STEP  20a. Method of Disposition	DAUGHTER_	20b. Place	of Dispo	317 LAKES sition (Name of		JE, BAL	TO., 20c. Lo	MD 21218 cation - City or To	wn, State
100	Pages ent of I nt: If It		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci				natory or other place LLE VET C		3/05	CROV	NSVILLE,	MD
Baltimore,	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other then eny injury or other traumatic event, Int. M. ADGE.		21. Signature of Funeral Service Lice		<u>M</u>		. Name and Addres		MES A. I	MORTO	ON & SONS	
			23a. Part1. Enter the disease, or conshock, or heart failure. List only	one cause on each I	ine.			_	-	-		Approximate Interval Between
).	Physician /Medical Examiner		tmmediate Cause (Final disease or condition resulting in death)	- MI	ROS s a consequence		ROTIC	Cardio	VASCUL	ak D	ISEASE	Onset and Death
1	peti usit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	s a consequenc	ce of):						
68760, <	ficate be executed physician and is the burial-transit	edical Examiner	that initiated events resulting in death) Last	Due to (or as	a consequen	ce of):						
_			IF FEMALE:					x-				
P.O. Box	that the death certifued by the attending detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetal dea	ath 3□	Ectopic pregnancy Other (specify)			2	23d. Date of delive Month	ny Day Year
of Vital Records, P.	w requires that the sbeen signed by the should be detached	Completed by Ph	Part II. Other significant conditions HYPERTER		but not resultin	g in the u	nderlying cause give	en in Part I.		obacco u Yes 2[	se contribute to th	
900	law as b	piet	HYDERLIPE	DEMIA					24a. Was		24b. Were autor	osy findings available inpletion of cause of
E. B.	The page	Com	DEMENT	<u> </u>					perfo	med?	death? 1 ☐ Yes	
Vita	Physician: The this certificate aldirector, pag	Be	25. Was case referred to medical examiner?	Hospital:			Othe	26. Place of Deat				
ō	shys this al di	): To	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date of Inj	ury 281	b. Time of	I JL DOA	4 Mursing Ho	ome 5 ☐ Resi 28d. Describe		Other (Specify y occurred	/)
ion	ath. r: After	atior	1	(Month, Da	ay Year)	Injury		<br Yes 2 □ No				
Division	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: Atter completely filled in by the funer.	Certification:	3 Suicide 6 Could not to determined	building, e	tc. (Specify)		eet, factory, office		City or To	wn, State,		
	the Hosp in 24 hou the Funer pletely fill	edicai	(Check only 2   Medical Exa	hysicien: To the best miner: On the basis of and manner s	of examination	dge, deatl and/or in	vestigation, in my or	oinion, death occur	and due to the red at the time,	date and	place, and due to	the cause(s)
	To To Con	Σ	29b. Signature and title of certifier	me	M	D.	Dow.		7		e signed (Month, I	
	541		30. Name and address of parson who	AR 1	1. D.	8	Print) 21 NORT	5845= HEUTAV	NST. 7	BALT	TIMORE	MD 21201
a	Sta Regist		31. Date filed (Month, Day, Year)	Regist	trar's Signature	Bos	de					7
DH	IMH 17 Rev 1/2	001	NUV ~ ~ =									

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Thomas Alexander Blackmore November 16, 2005 8:40A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 627 Muriel Street Rockville Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Nec . 25, 19 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 1 X M 2 □ F 577-42-9699 YES. Director 74 1930 Pennsylvania Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, the Wedical Examinant must be notified at 1 Yes 2 □ No Maryland Montgomery Rockville Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 627 Muriel Street 20852 United States Funerai death 12. Was Decedent Ever in U.S. Amed Forces? 1∑Yes 2 □ No Korean IrYes, Give Conflict Year or Dates: Vietnam 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. is 1 and 2 should be tiled within 72 hours after of Health and Mental Hygiene. Item 27 Is marked other than "natural", or Itei 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: 3 X Widowed 4 □ Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Lieutenant Commander United States Navy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Dwight Blackmore Florence O'Hara 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan L. Blackmore/Daughter 3348 Tennyson St., N.W., Washington, D.C. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date Pages 1 iment of F tant: If it 20c. Location - City or Town, State November 19 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State Montgomery Department of Important: If any injury or once. Crematorium, Inc. 2005 Bethesda, Maryland

22. Name and Address of Facility Robert A. Pumphrey Funeral Home/
Rockville, Inc. 300 West Montgomery Avenue
Rockville, Maryland 20850-2805 4 □ Qonation 5 □ Other (Specify) 21. Signatur Tuneral Service Lipansee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Heart Attack /Medical Due to (or as a consequence of) **Examiner** Dehydration Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed physician and the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical as the IF FEMALE esu. 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ţ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Chronic Renal Failure <u>Sleep Apnea</u> 24b. Were autopsy findings available prior to completion of cause of death? Heart Disease Arrhythmia 24a. Was an autopsy Hypertension 2 🗆 No 1 Yes 2 💢 No 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home SX Residence 6 Other (Specify) 1X Yes 2 □ No s after death.
I Director: Atter this of in by the funeral d 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ira Rabin, M.D. 10810 Connecticute Avenue, Kensington, Maryland 31. Date filed (Month, Day, Year) 32 Registrar's Signature State NOV 2 2 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month No. **Physician** Blackwell Day Quentin Richard 1:00 P M 16 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Kockville Under 1 Year If Under Shady Montgomer Adventist Grove 8. Date of Birth (Month, Day, Year) Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday If Under 24 Hrs. Birthplace (State or Foreign Country) Months Days Hours 1X1M 2□ F Director 511-03-2601 87 YES 1918 Kansas Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location or 28a-f show 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 X No Maryland Montgomery Potomac 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 8713 Victory Lane or itema 23a 20854 death by Funeral United States 12. Was Decedent Ever in U.S. Amed Forces? 1 ∰Yes 2 □ No World IYes, Give Year or Dates: War Ⅲ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Iten eny Injury or other treumatic event, the Medical Exemples. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No 3 ☐ Widowed 4 ☐ Divorced Specify: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) National Institute Elementary/Secondary (0-12) College (1-4or 5+) 5+Scientist of Cancer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ပ္ Virgil Richard Blackwell Ina Paisley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Blackwell/Son 131 South Edgewood Avenue, LaGrange, Illinois 60525 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) November 20c. Location - City or Town, State 1 ☐ Burial 2 🖔 Cremation 3 ☐ Removal from State Montgomery Crematorium, Inc. Crematorium, Inc. 20, 2005 Bethesda, Maryland

22 Name and Address of Facility Robert A. Pumphrey Funeral Home/
Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue

8 Bethesda, Maryland 20814-3501 4 □ Donation 5 □ Other (Specify) 20, 2005 21. Signature neral Service Live 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Sepsis disease or condition resulting in death) 30 hours /Medical Due to (or as a consequence of). Examiner oneumonia Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Dua to for se a consequence of) Examine use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy ģ in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. I ete has been signed by the page 2 should be detached 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, Coronary 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 PUnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificete 1 ☐ Yes 2 ☐ No 1 Yes 2. No Hospital or Attending Physician: After this certific funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 TYes 2 TNo 1 Inpatient 2 ER/Outpatient 3□ DQA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident the within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 61549 2005 Mushe poutre Nov 211 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Christine Lepoutre, M.D. 9901 Medical Center Drive, Rockville, Maryland 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 2 2 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1 Decedent's Name (First, Middle, Last) Month Day 200<sup>Y</sup>5<sup>ar</sup> **Physician** 0200 Butler 17 Timothy /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** NA Baltimore Good Samaritan Hospital If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1√2 M 2□ F Yrs. 213-64-5413 6-28-54 51 Md. Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene.

State 1 or Items 23s or 28s-f show 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County ir than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 □ No Director Baltimore NA Md. 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 21206 USA 5904 St. Regis Road Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11, Marital Status L Yes 2 No ¥Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes ¾☐ No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Baltimore City Waste Water Engineer permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygies Important: if Item 27 is marked other theny or other traumatic event, the Once. 12th Grade 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Sumame) Be Butler Bessie White W. Quentin 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21206 5904 St. Regis Road, Baltimore, Md. Wife Barbara Butler 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 11-22-05 Crownsville, Md. 4 Donation 5 ☐ Other (Specify) Md Vet. Cem. 21. Signature of Funeral Service License 22. Name and Address of Facility Baltimore, Md. 21202 1101 E. North Ave. March F.H. East Approximate Interval Between Onset and Death 23a. Part 1 Enter the disease, or complications that caused the deathock, or hean lailure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Cause (Final **Physician** Due to (or as a consequence of): cardiopil monder minute /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence ol) Examine attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 Agrobably 4 □Unknown certificate has been si irector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient Certification: To Yes 2 No 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident To the Funeral Director: 3 ☐ Suicide 6 ☐ Could not be 28l. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) determined 4 Homicide within 24 hours after To the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 1400 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7505 Oslan 31. Date liled (Month, Day, Year) 32. Registrar's Signature State NOV 2 2 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene 37554 For Stete Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Ihanie November19. 2005  $2 \cdot 00a$ /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Clinton Southern Maryland Hospital Prince Georges If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 X M 2 □ F 9/27/1923 239-30-7803 IN C Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examaner must be notified at 1 Yes 2 No Directo Prince Georges Clinton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 9211 Stuart Lane 20735 USA death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 XNo If Yes, Give Year or Dates: 11. Marital Status 1 Never Married 2 Married African Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: Specify: δ 3 Widowed 4 Divorced American Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) <u>Civil Servant</u> Civil 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jesse Battle Geneva Parks Battle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 618 Melvin Wrenn Rd. Yanceyville, NC 27379 Mell O. Battle / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If its
any injury or oth 1 Burial 2 Cremation 3 Removal from State Baldwin Cemetery 11/25/2005 Goldsboro, NC 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral HomeP. Aof B.C 9200 Liberty Road Randallstown, MD 21133 Print: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. MYOCARDIAL INFARCTION ACUTE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Dunknown 1 ☐ Yes 2 ☐ No ACCIDENT CEREBRO VASCULAR peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2ENO 2 No 1 Yes certificate the Hospitel or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 3 DOA 2 28a. Date of Injury (Month, Day Year) teref Director: After the filled in by the funeral 28d. Describe how injury occurred 27 Manner of Death 28b. Time of 28c. Injury at Work? Certification: 1 ANatural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours To the Funeref 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier NOVEMBER 19,2005 D 40324 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7503 SURRATTS ROAD, CLINTON, MARYLAND 20735 TERRY JODRIE, M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

			For Stete Registrar	State of M	laryland / Depa <i>Cei</i>	artment of He			iene g. Ne. 005	37555
	Physici		1. Decedent's Name (First, Middle, L	16	ngton			2. Date of Death	n Day Year	3. Time of Death  4.40pm
	/Medic Examin		4a. Facility Name (If not institution, g			4b. City, Town, or L			4c. County of Death	1
Ī	Funeral Director			Sex 7.A 1 □ M 2 💆 F	ge (In yrs. last birthday) 46 Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Dey, 03-01-195	Year) 9. Birth Cou	nplace (State or Foreign untry)
	ryland how		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	th the Ma or 28a-1 s	Director	MD NA 10e. Street and Number		Ba	10f. Zip Code		10	og. Citizen of What Co	1X Yes 2 □ No untry?
99	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 is marked other then "natural," or Items 23s or 28e-1 show other traumatic event, It is Medical Examiner must be mailined at	Funeral	2213 W. Pratt Str  11. Marital Status  **Tax*Never Married** 2   Married**	12. Was Deceden Armed Forces	? <b>T</b> No	21223 Was Decedent of Hisp If Yes, specify Cuban,	panic Origin? (Sp., Mexican, Puerto	ecify Yes or No- Rican, etc.)	USA cify Yes or No- lican, etc.)  14. Race - America Black, White, e	
Maryland 21215-0036	within 72 hours ene. than "natural", in Missical Ext	Completed by	3 Widowed 4 Divorced  15. Decedent's (Specify only highest g	Year or Dates: Education	16a. Dece (Give	dent's Usual Occupati kind of work done du DO NOT use retired)	ion	ing	Blac Blac Business/	
and 21	be filed wit ntal Hygiene ad othar the evant, Ille	Be	10 17. Father's Name (First, Middle, La.	st)		Laborer		e (First, Middle, N	Laundry faiden Sumame)	
Maryla	id 2 should be th and Mental 27 Is markad o traumatic eve	<u>و</u>	Willard W. Brewin  19a. Informant's Name/Relationship  Patricia Godwin / Si.	(Type, Print)		ng Address (Street an		al Route Number,	City or Town, State, Z	ip Code)
Baltimore,	permit. Pages 1 and 3 Department of Health Important: If Item 27 any injury or other to 9008.		20a. Method of Disposition  1  Burial 2 Cremation 3  4  Donation 5 Other (Special Control of Contro		20b. Place of Dispo	osition (Name of matory or other place)	1	Date 2	20c. Location - City or T	
Balti	permit. Depertm Imports any inju		21. Signature of Funeral Service UC	pres	2:	2. Name and Address	of Facility		lmor St. Balt	
	Physician /Medical		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	a	line.	ter the mode of dying, $UMOM \sim$ -	such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
	ecuted and transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Linter Uniterlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or a	s a consequence of):					
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rds, P	sign d be	by	Part II. Other significant conditions	contributing to death	but not resulting in the u	nderlying cause given	in Part I.		acco use contribute to	24
I Records,	The law ate has b page 2 s	Completed						24a. Was ar autopsy perform 1 Yes 2	prior to c ned? death?	topsy findings available ompletion of cause of 2 \sum No
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Division o	ding After fune	ation;	27. Manner of Death  1 Natural 5 ☐ Pending 2 ☐ Accident investigat		jury 28b. Time o lay Year) Injury	f 28c. Injury a Work? M 1 □ Ye	_	28d. Describe ho	w injury occurred	
Divis	e Hospital or Attand 124 hours after death a Funaral Diractor: letely filled in by the	Certification;	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	28e. Place of I	njury - At home, farm, st etc. <i>(Specily)</i>	reet, factory, office		28f. Location (Str City or Town	reet and Number or Ru , State)	ral Route Number,
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	ledical	(Check only 2 Medicel Ex		st of my knowledge, deat of examination and/or in stated.	vestigation, in my opi	nion, death occur	red at the time, da	ite and place, and due	to the cause(s)
)	To the within 2 To tha complet	M	29b. Signature and title of certifier	reduced House	e Officer	29c. License	148	29	Od. Date signed (Month	, Dey, Year) 2005
( <u> </u>			30 Name and address of person when the second secon	2000		nord still	T bul	timure,	Haryland Z	21723
1	Sta Regista		31 Date filed (Month, Day, Year) NOV 2 2 200	32. Regis	trar's Signature	e de la constante de la consta			1	

Barbara Cameron UNK 05-7780 AKG

			1 - State of Maryland Registrar	/ Department of Health and M Certificate of Death	ental Hygien Reg. ก็	
100	Physic	an	Decedent's Name (First, Middle, Last)	Canas and	2. Date of Death November	3. Time of Death 3:17 P M
	/Medi	cal	DARBARA  4a. Facility Name (If not institution, give street and number)	CAMERON  4b. City, Town, or Location of Death		c. County of Death
14	Exami	ner	Maryland General Hospital	Baltimore		NIA
9.	Funeral Director	2.2	5. Social Security Number 6. Sex 1 M 2 S F 7. Age (In yrs. la	st birthday) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Year MAY 17, 19	9. Birthplace (State or Foreign Country) 47 ALABAMA
	yland yland		Usual Residence of Decedent         10a. State         10b. County         10c. City,	Town or Location		10d. Inside City Limits
	death with the Maryland rns 23s or 28s-f show	ctor	MARYLAND N/A	BALTIMOR	RE CIT	1 No 1 No 1 No
	with th	Funeral Director	10e. Street and Number	10f. Zip Code	7 10g. C	Citizen of What Country?
	leath v	erai	11. Marital Status 12. Was Decedent Ever in U.S	. 13. Was Decedent of Hispanic Origin? (Spe	cify Yes or No-	14. Race - American Indian,
21215-0036	or ite	þ	Armed Forces?  1 Never Married 2 Married  3 Widowed 4 Divorced  Armed Forces?  1 Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puerio F	Rican, etc.)	Specify: BLACK
5-0		Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of workir	16b.	Kind of Business/Industry
121	be filed within 72 hotal Hygiene. Id other than "natu	id mo	Elementary/Secondary (0-12)  4 College (1-4or 5+)	MEDICAL ASSIST	TANT S	OCIAL SERVICES
d 2	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, the Mental Mental Control of the Mental Control of	Be Co	17. Father's Name (First, Middle, Last)		(First, Middle, Maide	
Maryland	Menta Menta arked	To	ROBERT L.	EAST SARA	H	MONTGOMERY
Mar	s 1 and 2 should f Health and Men Item 27 is marke other traumatic		19a. Informant's Name/Relationship (Type, Print)  KENNFTH (AMEGON (SON)	19b. Mailing Address (Street and Number or Rura.	Route Number, City	or Town, State, Zip Code)
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altimore,	Pages nent of nnt: Iff		1 Buriat 2 Scremation 3 Removal from State		3-05 B,	ALTIMORE, MO
Balti	permit. Pages 1 and 2 Department of Health a Important: If Item 27 It any Injury or other tra once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility BRO	SWN TR.	FUNERAL HOME BALTIHORE, MOZIZIT
	* .		23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.	Do not enter the mode of dying, such as cardiac or		Approximate finterval Between Onset and Death
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8760,	cate be executed obysicien and the burial-transit		resulting in death) Last Due to (or as a conseque	ance or):		
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Division of Vital Records, P.O. Box	Attanding Physician: The law requires that the death certific; r death, respectively the strength of the attending plactor. After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use as t	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 € No 9 ☐ Unknown  23c. If yes, outcome of pregnan 1 ☐ Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of dear	death 3 Ectopic pregnancy		23d. Date of delivery Month Day Year
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Vita	iician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?  Hospital: Hospital:	26. Place of Death		
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ion	ittending F death. ctor: Alter / the funer	atlo	1 □Natural 5 □ Pending (Month, Day Year) 2 □ Accident investigation (Month, Day Year)	2:41 PM 1 Yes 2-10 No	Housefire	£
ij	or Att	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - Af hombuilding, etc. (Specify)	ne, farm, street, factory, office	8f. Location (Street a City or Town, Sta.	and Number or Rural Route Number, 10) 2453 WWW. AVENUE
	spital ours a seral C		29a. Certifier 1 Certifying Physician: To the best of my know	ledge, death occurred at the time, date and place, a		(E, MD s) and manner as stated.
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edicai	(Check only and manner stated.			
	To the vithin To the company	Σ	29b. Signature and title of certifier	29c. License number		ate signed (Month, Dey, Year)
	4.		I M. Ott	O.C.M.E.	1/(	ovember 19, 2005
_	*		30. Name and address of person who completed cause of death (Item:	111 Penn Street, Balt	imore, Man	ryland 21201
炸	St Regist	ate rar	31. Date filed (Month, Day, Year) 32. Registrar's Signatu	It speeds		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death
Registry Mend Item #26 Per Verb G849 11/22/05 JII 2. Date of Death Month Day Year **Physician** John Joseph Clemens III 2005 19 NOV /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner N/A Union Memorial Hospital Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Sept 14, 1942 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral №** м 2□ F Canada 63 Yrs. 563-56-3015 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County r than "natural", or itama 23s or 28s-f ahow the Medical Example at most be motified at 1 Yes 2 □ No Funeral Director Maryland N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6924 McClean Boulevard 21234 Canada filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify Specify: White Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Machinist Manufacturing permit. Pages 1 and 2 should be filled v Department of Health and Mental Hygier Important: If itam 27 is marked other th any injury or other traumatic avent, tha since. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Isabel Mackey 2 John Joseph Clemens, II 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6924 McClean Boulevard Parkville, MD 21234 Cyril Scott Clemens, Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 11/20/05 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. Baltimore, Maryland Cremation Society Of Maryland Inc. 299 Frederick Road Baltimore, Maryland 21228 21. Signature of Funeral Servise Llows e Thomas Gregor 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sepsis **Physician** 19 day /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner sician and e burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a co nsequence of) Division of Vital Records, P.O. Box 68760, attending physic for use as the b IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day ō in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۾ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? page . 2 1 No 1 ☐ Yes After this certification funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Stiner (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 4 hours after death.

Funeral Director: All ely filled in by the fur M 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours at To the Funeral D completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Dey, Year) 29c License number 29b. Signature and little of 2438946 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Memoral Hospital Shaker 60

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

			For State Registrar	State of				t of H	ealth a		ental Hyg	iene	05	37558	
	hysicia /Medic Examin	al	1. Decedent's Name (First, Middle, Last  Hae R. C.  4a. Facility Name (If not institution, give  11103 Dewey Road	non street and num			Ken	sing		f Death	2. Date of Deal Month November	Day 20 4c. 0	County of Death	mery	
° ≱ Dir	neral ector		5. Social Security Number 6. Se 213-37-7809	x ]M 2∏F	'. Age (In yrs.	78 Yrs.	Months	1 Year Days	If Under: Hours	Min.	8. Date of Birth (Month Day),	Ý927	Sou	nplace (State or Foreign untry) th Korea	
e Maryland	illed at	ctor	10a. State 10b. County  Maryland Montgom	mery Kensin									10d. Inside City L _1 ☐ Yes 2		
with th	por 28	Dire	10e. Street and Number 11103 Dewey Road	10f. Zip Code 208						1		en of What Co	untry?		
<b>UU36</b> hours after death with the Maryland	d other than "natural", or feme 23s or 28s-1 show event, the Medical Examiner must be notified at	d by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Nover Married 4 Divorced	12. Was Decedent Ever in U.S. 13. V Armed Forces?			Was Decedent of Hispanic Origin? (Specify vif Yes, specify Cuban, Mexican, Puerto Ricar				Korea s or No- etc.)  14. Race - American Indian, Black, White, etc. Specify: Asian				
Ind 21215-16 be filed within 72 t tal Hygiene.	than "nati he Medica	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation le completed) College (1	4or 5+)		dent's Usua kind of wo DO NOT u memak	rk done d se retired	ation during mosi )	t of worki	ng		of Business/ wn Home	•	
Maryland 21215-0036 d 2 should be filed within 72 hours af th and Mental Hygiene.		To Be C	17. Father's Name (First, Middle, Last) UNK •					18. Mother's Name (First, Middle, Main Kim MJ					aiden Surname)		
Mar)	item 27 is marke other traumatic		19a. Informant's Name/Relationship (T		14		•				Al Route Number	-			
s tand f Healt	item 2		Ok K. Van Brunt,		20b.	Place of Dispo cemetery, crei	sition (Na	ne of			ngton,		Land 20 ation - City or		
Baltimore, permit. Pages 1 ar Department of Hea	important: if eny injury or once.		1 ☐ Burial 2 【Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify,			letro C	remat	ory	Inc.					, Maryland	
Baltimore, permit. Pages 1 an Department of Heal	eny in		21. Signal report Funeral Saylee Licens Roman Inulias Gregor	600		2	Name ar	tion	Soci	ety Road	Of Mary	land	Inc.	and 21228	
Phys	sician edical		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	lications that can be cause on ea	aused the dea ach line.	th. Do not en	ter the mod	de of dyin	g, such as	cardiac o	or respiratory arr	est,		Approximate Interval Between Onset and Death	
760, te be executed	miner	Ical Examiner	S uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	or as a consec										
<b>Records, P.O. Box 68</b> The law requires that the death certifical	ed by the attending physicien and detached for use as the burial-transit	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 2 No 9 ☐ Unknown		rth 2 ☐ Fet ant at time of	al death 3	⊒Ectopic p ⊒ Other (s <sub>f</sub>					2	3d. Date of del Month	ivery Day Year	
rds, P.	been signed by should be deta	۵	Part II. Other significant conditions co	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to								the cause of death?			
Records, The law requires t	SO	Completed								24a. Was a autop: perfor 1 Yes	sy m <b>e</b> d?	prior to death?	ntopsy findings available completion of cause of		
Vital	ector.	Be	25. Was case referred to medical examiner?	Hospital:	200		2018150	Oth	00		Check only or				
Division of Vita to Attending Physicien: after death.	To the Funeral Director: After this certificate ha completely filled in by the funeral director. Pege	tlon; To	1 Yes 2 No  27. Mapner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury 28b. Time of Injury				28c. Injur Wor	y at		ome 5 Residence 6 □Other (Specify)  28d. Describe how injury occurred			cify)	
DIVISI	al Director ad in by the	Certification;	3 Suicide 6 Could not be 4 Homicide determined					28f. Location (Street and Number or I City or Town, State)				ıral Route Number,			
Hospital 24 hours a	Funeri etely fill	edical	252 Cartiflat 1 Certifying Ph (Check only 254 Medical Examone)	iner: On the ba	beet of my kn isis of examin her stated.	owledge, deal ation and/or in	th oscillated rvestigation	at the tire, in my o	pinion, dea	id place ith occurr	and due to the cred at the time, o	ate and	and manner an place, and due	to the cause(s)	
To the within 2	To the	Me	29b. Signature and title of certifier	ino !	(OVNE)		29	C. Licens	e number		29d. Date signed (Month, Day, Year) NOW SELL (1), LOS				
			30. Name and address of person who o	completed caus	e of death (Ite	m 23a) (Type, NO (KUILC	Print)	· do	exvice	e, p	0 20852				
- ANGEL - A	Sta Regist		31. Date filed (Month, Day, Year)	A	egistrar's Sign	nature	S. a								

ORIGINAL

			For State Registrar	State of Mary		artment of H		Mental Hy	6. 00	15	37559	
			Registrar  1. Decedent's Name (First, Middle, Last)			Timouto or i	Doutin	2. Date of De	Reg. No.		3. Time of Death	
	Physici	an	Month Day Year									
	/Medic		W. NICOLE Hardesty Callanan 11/15/2005									
1	Examin	er	Baltimore Washi		d Ctr	Glen B			Anne	Aru	ndel	
	Funeval		5. Social Security Number 6. Sex		n yrs. last birthday	If Under 1 Year	If Under 24 Hrs	8. Date of Bi	et b		place (State or Foreign ntry)	
	Funeral Director		218-45-9259	M 2 <b>2</b> F	9 Yrs.	Months Days	Hours Min.	12/21	/1995	Coul	MD	
	D		Usual Residence of Decedent								10d Incide City Limits	
	trylen thow	_	10a. State 10b. County	10	Oc. City, Town or L	ocation					10d. Inside City Limits 1 ☐ Yes 2 No	
	88-18	cto	MD Anne Ai	rundel	Glen E							
	or 24	Dire	10e. Street and Number			10f. Zip Code			10g. Citizen of V		ntry?	
	23a	'as	7580 Brightwate			21060		W Al	U.S. 7		can Indian.	
	item item	Funeral Director	11. Maritar Status	12. Was Decedent Eve Armed Forces?	or in U.S. 13.	Was Decedent of H If Yes, specify Cuba	an, Mexican, Puer	to Rican, etc.)		ck, White,		
36	2 should be filed within 72 hours after death with the Marylend and Mental Hygiene. is marked other than "natural", or iteme 23s or 28s-f show summatic event, the Medical Exteniner must be notified at	by F	1 Mover Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 M No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No	Specify:		Specify	" Wh	ite	
21215-0036	tura	pa	15. Decedent's Educ		16a. Dece	edent's Usual Occup	pation		16b. Kind of B	usiness/Ir	ndustry	
15	n n	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Giv	e kind of work done DO NOT use retired	during most of wo d)	rking				
212	the piece	E	5	College (1940) 37)								
	Hygie other	0	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle	a, Maiden Suman	10)		
<u>la</u> r	should be tand Mental I	To B	Kyle E. Callaha	an, Jr.				ah A.				
Maryland	and h		19a. Informant's Name/Relationship (Ty	oe, Print)							<sup>o Code)</sup> 21060	
	ges 1 and 2 should t of Heeith and Men if item 27 is marke or other traumatic		Kyle Callahan,			-	water E				Burnie, MI	
ore.	of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R	- 1	20b. Place of Disp cemetery, cre	osition (Name of ematory or other plac	ce)	Date	20c. Location -	City or To	own, State	
Baltimore,	permit. Pages 1 Depertment of H importent: if ite any injury or ot once.		4 Donation 5 Other (Specify)	Sinoval nom Clare	Glen Ha	aven Mem	Pk 11/	19/05	Glen :	Burn	ie, MD	
alt	permit. Depertrimports imports any inju		21. Signature of Faneral Service License	99	2	22. Name and Addre	ss of Facility G .	J.Gonc	e Fune	ral	Home, PA	
Ω	89 5 8 9		23a. Part1. Enter the disease, or compli			.69 Rivi				, MD		
				Approximate Interval Between Onset and Death								
	Physician		Immediate Cause (Final disease or condition Cardiopulmonary Arrest 1 Da									
4	/Medical		resulting in death)	Due to (or as a c								
	Examiner		Sequentially list conditions,	Hyperte								
	D #	ner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a c							Since	
	ate be executed obysicien and the burial-transit	Examiner	Cause (Disease or Injury that initiated events resulting in death) Last	Seizure  Due to (or as a c		der					Birth	
90	Sien surial	<u> </u>	rosaning in down, exist			_					Since	
8760,	cate b	dicai		cerebra	al Palsy	/					Birth	
9	The law requires that the death certificate be executed site been signed by the ettending physicien and page 2 should be detached for use as the burial-transit	Me.	IF FEMALE:	3c. If yes, outcome of	oregnancy				224 02	to of dollar	1001	
Вох	ath c	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 [ 4 ☐ Pregnant at tim	Fetal death 3	□Ectopic pregnancy	у			ite of deliv onth	Day Year	
	the the	ysic	1 □ Yes 2 MZNo 9 □ Unknown	9☐ Unknown	ie or death 5	Other (specify)						
P.O.	that the de ed by the detached	F.	Part II. Other significant conditions cor	tributing to death but r	not resulting in the	underlying cause giv	ven in Part I.	23e. Did	tobacco use cont	tribute to 1	the cause of death?	
ds,	sign d be	d by	Mental Retarda	tion				1	Yes 2 No	3 Pro	bably 4 DUnknown	
ŏ	w require been si	ete	Coution! Dlind					24a. Wa	san 24b.	Were aut	opsy findings available	
Records,	hes pe 2	Completed	Cortical Blind	ness				auto	opsy ormed?	prior to co death?	ompletion of cause of	
a			Scoliosis				on Disease of De	1 ☐ Yes ath (Check only	- 1/	1 🗌 Yes	2∐ No	
Division of Vital	Physicien: r this certific ral director,	Be	25. Was case referred to medical examiner?  1 X Yes 2 No	lospital:	2 ER/Outpatie	ent 312 DOA Oth	or		sidence 6 Oth	ner (Snec	(fv)	
of	Phys rat di	1.7	27. Manner of Death	28a, Date of Injury	28b. Time				how injury occur		•97	
on	ding h. Afte fune	盲	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Y	'ear) Injury		rk? ∣Yes 2∐No					
ISI	deal deal ctor	fica	3 Suicide 6 Could not be	28e. Place of Injury	- At home, farm, s	treet, factory, office			(Street and Numb	per or Rur	al Route Number,	
ă	effer Dire d in b	Certification:	4 Homicide	building, etc. (	'Sр <del>в</del> сіту)			City of 1	JWII, SIRIE/			
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: Atter th completely filled in by the funeral		29a. Cartifier 1 Cartifying Phys	sician: To the best of a	ny knowladge, dat	offi occurred at the th	ina, date and plac	e, and due to the	cause(s) and me	anner as i	stated.	
	He Ho	Medicai	(Check only 2 Medical Exami	ner: On the basis of ex and manner state		nvestigation, in my o	opinion, death occ	urred at the time	, date and place,	and due t	to the cause(s)	
	withir To th	ž	29b. Signature and title of certifier	1	_	29c. Licens	se number		29d. Date signe	d (Month,	Day, Year)	
			Na Z	1m -		D2	9800		11/1	17/	05	
1	LVI		30. Name and address of person who co	ompleted cause of deal	th (Item 23a) (Type	e, Print)						
	)		Dennis Lee, M.			rain Hwy	, #307	Glen	Burnie	, MI	21061	
		ate	31. Date filed (Month, Day, Year)	32. Registrar	Signature							
	Regist	rar	NOV 2	2 2005	due Li	Angel	,					
DH	MH 17 Rev 1/2	001										

	1 - For State Registrar			of Maryl	and / Dep		t of H	ealth a	and Me		giene Reg. No.	005	,	7560
Physician	Decedent's Name (First, Middle, Last)     RUTH ESTELLE CALDWELL								2. Date of De Month	Day 16	2005	ır	3. Time of Death ジナ45 M	
/Medical Examiner	4a. Facility Name (If not ins	ritution, give s	treet and nu	ımber)		4b. City,	Town, or	Location of	of Death			County of D		
	Stella Mari	S						ore (				Balt	imo	re
Funeral Director	5. Social Security Number 212–14–2956		: ]M 2⊠F	7. Age (In ) 91	vrs. last birthday, Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Bi (Month, Di July 1	9. Birthplace (State or Ford Country) 17, 1914 Maryland			/)
land ow	Usual Residence of Deceder 10a. State 10b. C			10c.	. City, Town or L	ocation							100	I. Inside City Limits
with the Marylan or 28a-f show the control of the c	Pennsylvania	York C	Co.		Wi	ndsor								1 ☐ Yes 2 🛣 No
with the last or 2 Liberth II		S+				10f. Zip		366			-	en of What JSA	Country	y?
ms 23	11. Marital Status		12. Was Dec	edent Ever i	n U.S. 13.	Was Deced			gin? (Spec	cify Yes or No Rican, etc.)		4. Race - A		
d 21215-0036 Illed within 72 hours after death with the Maryland Hygiene. Hygiene. And I the Medical Examinat must be traitified at an experiment the character of the manual beautified at a Completed by Funeral Director	1 □ Never Married 2 □ 3 ☑ Widowed 4 □ Div		Armed Fr 1 Tyes If Yes, G Year or I	<sup>2</sup> ∑XVo ive		1 ☐ Yes			i, Puerto H	tican, etc.)		Black, W Specify:	White, etc.	
Maryland 21215-0036 at 2 should be filed within 72 hours aff till and Mental Hygiens in natural; or 27 is marked other than "natural; or rtraumatic evant, the Medical Evant To Be Completed by F	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Elementary/Secondary (0-12) College (1-4or 5+)  N / A HOUSEWIFE HOUSE								ekeeping-Own Home					
d 212 filed with Hygiene other tha ant. The		iddla Last)	N/ <i>F</i>	Α	HOU	JSEW1I	e	19 Matha	do Namo	(First, Middle		<u>'</u>	.ng~	OWII HOINE
E Safe D	Carroll Spu	rry						Ann:	ie Ty	dings		,		
ore, Maryla	19a. Informant's Name/Rel				ter) 232	3 Amos	s Mi	11 Rc	r or Rural L. Py	Route Numb	er, City or le, M	Town, State 1d . 21	, <i>Zip C</i> 132	ode)
Baltimore, bermit. Pages 1 ar Department of Hea mportant: If item any injury or otha	20a. Method of Disposition  ★ Burial 2 □ Crem  4 □ Donation 5 □ Ot		emoval from	State	b. Place of Disp cemetery, cre			1		9~05		cation - City timore		
Baltimor. permit. Pages Department of t Important: If its any injury or of	21. Signature of Funeral Se	rvice License		/	2	2. Name an	d Addres	s of Facilit	v	740 e Bal	1 Bel	air R	d	
are be executed are be executed Invision and the burial-transit the bu			Due to	(or as a con	sequence of): sequence of):	COU	ris							Inset and Death
ecords, P.O. Box 68760, faw requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit pleted by Physician/Medical Examir	IF FEMALE: 23b. Was decedent pregna in the past 12 months 1 □ Yes 2 ₩ No 9 □ Unknown	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 MNo  23c. If yes, outcome of pregnant 1 Live birth 2 Fetal of 4 Pregnant at time of dea							eath 3 Ectopic pregnancy					
rds, P quires that n signed balld be deta	Tartii. Other alginitourit of	nditions cor	ntributing to d	death but not	resulting in the u	inderlying c	ause give	n in Part I.						cause of death?
~ º - 8 E										24a. Was auto perfo 1 \( \text{Yes}	psy prmed2/	24b. Were prior to death	autopsy o comp ? es 21	y findings available letion of cause of
Vital I vician: The certificate rector, pag		<b>⊢</b>								(Check only	опе)			
vision of Vita Attending Physician: ar death.	1 ☐ Yes 2 ☐ No	Pending nvestigation		Inpatient 2 of Injury oth, Day Year	2 ER/Outpatie 28b. Time o Injury		8c. Injury Work	at ? es 2 🗆	28			dence 6 Other (Specify) now injury occurred		
Division c tal or Attending P tal or Attending P tal Director: After t led in by the funera Certification:	3 ☐ Suicide 6 ☐ 6 4 ☐ Homicide	Could not be letermined						28	28f. Location (Street and Number or F City or Town, State)			Rural R	loute Number,	
DIVIS To the Hospital or Attevithin 24 hours after de within 24 hours after de completely filled in by the Medical Certific	29a. Certifier 1 Ce (Check only 2 Me	rtifying Phys dical Exami	ner: On the t	e best of my basis of exam nner stated.	knowledge, dea nination and/or in	h occurred vestigation	at the tim , in my op	e, date an inion, dea	d place, ar th occurred	nd due to the d at the time,	cause(s) a date and p	and manner place, and d	as state	ed. e cause(s)
To th withir To th comp	29b. Signature and title of	ertifier				290		number				signed (Mo		
	eunea	axon	Is .	M.D.			Dia	619			NOV	SMBEL	2 /	6, 2005
3	30. Name and address of p						יזת ח	TANTES	7 777 7	TEV DA	7 D "	77 880 87 7	TT## 1	MD 21002
State	CORAZON  31. Date filed (Month, Day,	Year)					U DU	LIPAINE Y	VAL.	LEY RO	AD 1	TMONT	UM I	MD 21093
Registrar	NOV	2 2 200	15	BE45.1	ignature	and a								

DHMH 17 Rev 1/2001

7:45 A.M.

NOVEMBER 16, 2005

CALDWELL, RUTH

			For State Registrar		State o	f Maryl	land / De	partmen e <i>rtificat</i>	t of H e of L	lealth a D <i>eath</i>	and N	Mental Hy	/giene	)5	37561
	Physici /Medi	cal	Decedent's Nam     Aa. Facility Name //	elyo	give street and nui	ar mber	ter,	Sr-	Town or	Location	of Death	2. Date of D Month Novemb	ver Day 4th	Year 2005 ty of Death	3. Time of Death 5.35 A M
	Examir	ier	Harborsid				L.		_		oi Death		n/		
	Funeral Director		5. Social Security N 216-24-27	lumber	6. Sex 1 <b>⊠</b> M 2 ☐ F		yrs. last birthda 76 Yrs.	y) If Under Months	Timo 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D			
	pu »		Usual Residence of	f Decedent		1.0.	0); T								
	Aaryla Fahov Fall	ō	MD	10b. County			. City, Town or							1	0d. Inside City Limits 1   Yes 2  No
	the A	Director	10e. Street and Nu	n/a		В	altimor	10f. Zip	Code				10g. Citizen of	What Cour	
	3e or		4700 Hai		1								United		,
	deati	Funeral	11. Marital Status	LIUIU NO	12. Was Dece	7		B. Was Dece	1214 lent of Hi	spanic Ori	igin? (Sp	ecify Yes or N	o- 14. Ra	ce - Americ	an Indian,
36	72 hours after death with the Maryland naturel', or items 23e or 28a-f show dical Examinat noust be rodified at	by Fu		ied 2 Marrie	If Yes, Gr	2 □ No <b>1</b>		1 ☐ Yes		n, Mexicar Specify:		Rican, etc.)	1	ack, White, ify: <b>Whi</b>	
21215-0036	72 hours "naturel", dical Exa	ed b	3 XWidowed	15. Decedent's	Year or D	ates: 1	949	cedent's Usua	al Occupa	ation			16b. Kind of I		
215	C 9	Completed	(Spec	cify only highest	grade completed) College (1	1-4or 5+)	(Gi	DO NOT u	rk done a	lurina mos	t of work	ing	TOB. KING OF	Jusii 1633/1110	Justry
	filed within Hygiene. sther then shift the Market here.	Com	4				Tool	L & dy	e				manuf	actur	ing
and		Be	17. Father's Name		•								, Maiden Suma	me)	
Maryland	should bond marked marked	L C	Elmer Jo		2011		10h Ma	iliaa Adda	/C1===1=			ce Phea			
	S 50 50 50				r. / son								овг, City or Towr <b>1 21221</b>	, State, Zip	Code)
Baltimore,	0 - = =		20a. Method of Disp	'	3 □Removal from		b. Place of Dis	position (Nar. rematory or o	ne of ther place	9)	ľ	Date	20c. Location	- City or To	wn, State
Ē	Pa Int:		° 4 ☐ Donation	5 ☐ Other (Spe	ecify)	B	Bayview		-						Maryland
Ball	permit. Pag Depertment Important: I any njury c		21. Signature of Fu	in ri Service	icensele LLAM	l									f Lansdown 1and 21227
	Fnysician		Immediate Cause disease or condition	(Final	omplications that conly one cause on e	aused the dach line.	Heath. Do not e	6	. 0	such as	cardiac	or respiratory a	urrest,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Ì	Due to (	or as a con	seque (c/ of):		41		- /			-	1
0, 6	ficate be executed physician and s the burial-transit	Examiner	Esquentially list confidence if any, leading to imcause. Enter Unde Cause (Disease or that initiated events resulting in death) I	orlying injury	c		sequence of):	Vou	Jun	nu	ia	× ·		G	ae nour
38760,	ficate be physici s the bu	dical			d										
.O. Box (	death certii e attending id for use a	Physiclan/Me	IF FEMALE: 23b. Was decedent in the past 12 1  Yes 2  9  Unknown	months? □No		irth 2 ☐ F ant at time	etal death 3	□Ectopic pr □ Other (sp						ate of deliver	y Day Year
ds, P	es pe	ρ	Part II. Other signif	icant condition	s contributing to de	ath but not	resulting in the	underlying ca	ause give	n in Part I.			obacco use con Yes 2 □ No	tribute to the	e cause of death?
Record	> 40 0	ompleted										24a. Was	an 24b.	Were auton	sy findings available
_	The ate h	e Com	05.11									1 Yes	psy prmed? 2DNo	prior to com death?	pletion of cause of
Vital		0 8	25. Was case reference examiner? 1 ☐ Yes 2 😿		Hospital:	npatient 2	⊇ ☐ ER/Outpati	ent 3 DO	, Othe			Check only			22.70
	ding h. After fune	$\vdash$	27. Manner of Death  1 Natural 2 Accident		28a. Date of		28b. Time	of 2	Bc. Injury Work	at	1		dence 6 □Oth how injury occur		
=	el or Attendi s after death il Director: A ed in by the fi	Certification:	3 Suicide 4 Homicide	6 Could no determin	led 286 Place	of Injury - Ang, etc. (Sp	At home, farm, s ecify)	treet, factory	, office		2	28f. Location (. City or Tou	Street and Numb wn, State)	ber or Rural	Route Number,
	To the Hospitel or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	edical (	29a. Certifier (Check only one)	1 Certifying 2 Medical E	Physician: To the xaminer: On the ba and mann	isis of exam	iination and/or i	nvestigation.	in my opi	inion, deat	th occurre	ad at the time	date and place	and due to	the causeo(c)
)	To the within 2 To the I complet	×	29b. Signature and	title of certifier	Trif	reu	eer	290	D 3	number 0 6 6	/		29d, Date signe	g (Month, D	1239
			30. Name and addre	ess of person w	ho completed cause	e of death (i	Item 23a) (Type	Print)	0-		72.		Zair 1	$n$ , $\gamma$	.220
	Sta	te	31. Date filed (Mont	th, Day, Year)	URANET 32. Re	egistrar's Si	gnature p	LOCH	MAY	EN	01	va L	11110,1	ild L	1237
	Registr		NOV 2	2 2 2005	Ella Best	D.	MARKE								

State of Maryland / Department of Health and Mental Hygie ( ) 5 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Jerome Campion November 20, 2005 3:00 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7528 Race Road Hanover Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 F Director 218-14-0918 82 Yrs. 7, 1923 Jun. Maryland Usual Residence of Decedent with the Maryland wode 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits treumatic event, the Medical Examiner must be notified at Director MD Anne Arundel 1 ☐ Yes 2 No Hanover 28e-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ or Items 23e 7528 Race Road 21076 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 22 Yes 2 D No 1 - 30 - 43 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ont: If item 27 is marked other then "netural", or ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🏋 No þ Specify: White 3 ☐ Widowed 4 ☐ Divorced 1-11-46 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Howard County Elementary/Secondary (0-12) College (1-4or 5+) 6 Mechanic Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First Middle Maiden Sumame) Be George Campion Lottie Pearl Kisner 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or other tre Doris M. Campion Wife 7528 Race Road, Hanover, MD 21076 20b. Place of Disposition (Name of Meadow Tidge or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Denation 5 Other (Specify) Memorial Park 11-23-2005 Elkridge, MD 21. Sign tour of Funeral Service Alcert 22. Name and Address of Facility Ambrose Funeral Home, Inc. 328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 9 mi **Physician** myelodysplatic syndromé disease or condition resulting in death) /Wedical Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner anding physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 5 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ signe be 2XNo 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy 20 No Vital 1 ☐ Yes the Hospitel or Attending Physicien: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Cther: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After Division 1 Natural 5 Pending death. investigation М 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deat To the Funeral Director; completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D32374 Y) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BACTIMORE MD 21229 Co 2 60P QM tonave Siglli Mydloris Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 2 2 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year George W. Covington Jr. NOVEMBER 15 2005 /Medical If Under 1 Year If Under 24 Hrs.

Norths Days Hours Min.

06-01-1925 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GOOD JAMARITAN 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) North Carolina **Funeral** 1**∑**M 2□F 238-24-2052 Yrs Director 80 Usual Residence of Decedent with the Maryland 10a. State 10h Counts 10c. City, Town or Location 10d. Inside City Limits or 28a-f show traumatic event, the Medical Examiner must be notified at Director 1 XYes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23a 1406 N. Linwood Avenue 21213 USA Pages 1 and 2 should be filed within 72 hours after death vann of Health and Mental Hygiene. Sant: If item 27 Is marked other than "natural", or Items 23 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: 3 XWidowed 4 □ Divorced Black Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Steel Worker Stee1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George W. Covington Sr. Hannah B. Woods 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 Is any injury or other trace Wanda T. Covington/ Daughter 1406 N. Linwood Avenue Baltimore, MD 21213 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest Vet. Cem 1 4 ☐ Donation 5 ☐ Other (Specify) 11-23-05 Owings Mills, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Wylie Funeral P.A. 638 N. Gilmor St. Balto, MD 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ENCEPHALOPATHY Pnysician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last as the burial-to Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.O. I ed by the a detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by CARDIO MY OPATHY 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 21**X**No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 R/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Leath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending 24 hours after death. Funeral Director: A 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Thomicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 24 hor To the Fune completely fi (Check only one) 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) 1018230 5601 LOCH RAVEN BOULEVARD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHASHIDHARAN, MD KALATHIK BALTIMORE, MD 21239 2. Registrar's Signature 31. Date filed (Month, Day, Year) NOV 2 2 2005 Registrar

Certificate of Death

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

NOV 2 2 2005

32. Registrar's Signature

Feng Xia Dai 05-7681 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 05 1 - For State Registrar Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November, Year **Physician** 8:59 PM HENG-XIA 13 7005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner rince George's Country HOSPITUL Prince George Cheverly If Under 1 Year | If Under 24 Frs 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 5. Social Security Number 9. Birthplace (State or Foreign Funeral 1 M 2 XF Hours 578 198185 Months Days Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show itema 23a or 28a-f ehov mar nijust be notified at WASHINGTON 1 Yes 2 No Directo 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? 338 20002 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status other traumatic event. The Mudical Examinant 1 Yes 2 No
If Yes, Give (
Year or Dates: 1 ☐ Never Married 2 Married ö 1 ☐ Yes 2 📉 No Baltimore, Maryland 21215-0036 Spacity: Chinese Specify 3 ☐ Widowed 4 ☐ Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) WEB DEVELOPER PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be marked o BAOLIAN ို 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 338 G St. N.E. if Health WASHINGTON DC HUSBAND NING 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ö Department of Important: If any injury or once. RIVERDALE PARK CREMATORY RIVERDALE, MD 21. Signature of Funeral Service Licensee UNERAL SERVICES, INC FORGIA AVENW WASH. DC 20011 23ar Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy signed by the atte in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown certificate has been s rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No 1 ☐ Yes 2 ☐ No of Vital 25. Was case referred to medical examiner?

1 Yes 2 No the funeral director Be 26. Place of Death | Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification; To 28d. Describe how injury occurred De Ceased
Driver D Car Crossed with
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Driver D Car Crossed with D Car Crossed 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? After 1 Natural 5 Pending investigation after death. 11-12-05 1 ☐ Yes 2 XNo 2 Accident 3 ☐ Suicide 14:36 PM 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: Un the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 hours a

To the Funeral C To the Hospital 29a. Certifier one) 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) D.C. M.E Hovember H. 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

2.12.

Penn Street, Baltimore, MD ZIZOI 111 7. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Yea Jennie Marv Dicus 9:45p. M NOVEMBER 18 2005 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death GlenBurnie Bouttimore Washington modical Confer meanindo 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Jul 29, 1922 **Funeral** 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) 1 ☐ M 2 💢 F 83 Director 216-12-5926 MD. Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 28a-f show 10d. Inside City Limits treumetic event, the Medical Exeminer must be notified at Director MD. 1 Tyes 2 No Anne Arundel Pasadena 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? ò or items 23a 8012 Ellizabeth Road 21122 U. S. A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify Specify: White 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NDT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home is marked other 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Stephen Kuczinski 2 Jennie Andrcejeski 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Importent: If item 27 is any injury or other trei once. Mrs. Katherine Westerfield 1222 Adams Road Waldorf MD 20602 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town. State 1 XBurial 2 Cremation 3 Removal from State Nov 23 2005 `4 □Donation 5 □ Other (Specify) Meadowridge Menorial Elkrid e MD 21. Signature of Funeral Survice License 22. Name and Address of Facility Singleton Funeral Home, P.A. Second Avenue SW Glen Burnie MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Vascular Cerebro Accident /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, any, leading to ministrate cause. Enter Underlying Cause (Disease or injury Examiner Dua to for as a consequence offi Hospitel or Attending Physicien: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 the attending physicien Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. After this certificate has been signed by the a funeral director, page 2 should be detached it 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death Director: / 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funerel L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00055973 Kassahun M.D belche NOVEMBER 18, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2eleke 11500 DESSE Sutherland hin WOU SITTER Spring 31. Date filed (Month, Day, Year) 2 2005 32 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Dete of Deeth 3. Time of Death Month Dey November 21, **Physician** Alice Witte Doyle 2005 5:50 AM /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street and number) 4c. County of Death Examiner Brightview Assisted Living Catonsville Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer Sept.9, 19 9. Birthplace (State or Foreign Country) Mary Land 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2 💢 F 1928 Yrs 77 Director 214-24-6568 Usuel Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours efter daath with the Meryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or itams 23s or 28s-f ahow 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or itams 23a or 28a-f ahow traumatic avent, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Baltimore Catonsville 10e Street end Number 10f Zip Code 10g. Citizen of What Country? Funeral 21228 2205 Belleview Road USA 12. Was Decedent Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Merried 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. White Specify Be Completed by 3 ™ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify onfy highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Witte Alice Wenderoth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2614 Turf Valley Road; Ellicott City, MD 21042 Nancy Spicer Daughter 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 5 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 11/28/05 Pikesville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Druid Ridge Cemetery 21. Signature of Superal Service License 22. Name and Address of Facility Witzke Funeral Home of Catonsville, Inc. 401290 1630 Edmondson Avenue; Catonsville, MD 21228 complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, 23a. Part1. Enter the disease shock, or heart failure. Approximate Interval Betw Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Atherosclerosis nut leaver Examiner Due to (or as a consequence of): Examiner Lym nhoma onemor ettending physician and for usa as the burial-transit The lew requires thet the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as e consequence of) signed by the eld be detached f 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown þ Completed 24b. Were autopsy findings available prior to completion of ceuse of deeth? been si should 24a. Wes en autopsy performed? has page 2 2 No 1 ☐ Yes 2 ☐ No 1 Tes certificata Hospital or Attending Physician: director, Be 25. Wes cese referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) e 1 Yes 2 No this 27. Menner of Death 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: After Natural 5 ☐ Pending neral Diractor: A 1 Tyes 2 □ No 2 ☐ Accident investigation 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide hours after within 24 hours a

To the Funeral Completaly filled edicai 🏿 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Ste 10057069 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) Julie Steiner 700 (cim Catonsville MD 31. Dete filed (Month, Day, Year) 32 Segistrar's Signature State Registrar

**ORIGINAL** 

DHMH 16 Rev 6/95

		•	State of Maryland / Department of Health and M  1- For Amend item 17&18 per fh G849 1-29=05 tas Certificate of Death	lental Hygier	2005 37568
	Physicia	an	1. Decedent's Name (First, Middle, Last)  A L FONSO ROOSEVELT EDWARDS	2. Date of Death	Oay Year
	/Medic Examin		4a. Facility Name (If not institution, give street and number).  4b. City, Town, or Location of Death		4c. County of Death
		٠.	GOOD SAMARITAN HOSPITAL BALTIMORE		NA
	Funeral Director		5. Social Security Number  6. Sex 12 M 2 F  7. Age (In yrs. last birthday) 15 Under 1 Year 16 Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea MARCH Co.)	9. Birthplace (State or Foreign Country) 1933 VIRGINIA
	land		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	,	10d. Inside City Limits
	be filed within 72 hours after death with the Maryland tal Hygiene. Id all Hygiene. Id other than "natural", or Items 23a or 28e-1 show event, I're Medical Esain and must be notified at	tor	MARYLAND BALTIMORE TOWSON		1 ☐ Yes 2 No
	or 28	Funeral Director	10e. Street and Number 10f. Zip Code	10g. (	Citizen of What Country?
	s 23a	ral	305 E. JOPPA RD. APT 1504 2128	6	14. Race - American Indian,
	Item	-une	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married	Rican, etc.)	Black, White, etc.
036	al', or	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give 1 ☐ Yes 2 ☑ No Specify:		Specify: BLACK
21215-0036	72 hc	Completed	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of works (file. DO NOT use retired)	ing 16b.	Kind of Business/Industry
121	within ene. than "	ompl	Elementary/Secondary (0-12) College (1-4or 5+)  12 THGRAPE  College (1-4or 5+)  MILITARY MAN	1 /	1.5 1/4/1/
	should be filed withir of Mental Hygiene. marked other than matic evant, ILL M	Be Co		e (First, Middle, Maid	
Maryland	Mental Mental arked o	To E	ROLAND KYTANI EDWARDS SK. BERI	NICE	Anderson
Jan	2 should hand his ma		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rura	al Route Number, Cit	10
_	ges 1 and 2 should tof Health and Men If item 27 is marke or other traumatic			Date 20c.	Location - City or Town, State
nor	Pages nent of I int: If its iry or o		12 Burial 2 Cremation 3 Removal from State  14 Donation 5 Other (Specify)	28-050	muse muse MA
Baltimore,	그 돈 말 글				R. FUNERAL HOME
ä	Depar Depar Impo any ir		Lichel N. Williams 2140 N. FULTON	AVE	BALTO
П			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of shock, or heart failure. List only one cause on each line.	or respiratory arrest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. FRUBABLE MYDICARDIAL TWFARD	TION	UNKNOWN
b	Examiner		Due to (or as a consequence of):		
		ner	Sequentially list conditions, if any, leading to firm ediate cause. Enter Underlying		
	and transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):		
8760,	icate be executed physician and s the burial-transit	Ical E	resulting in death) Last Due to (or as a consequence of):		
687	ficate g phys	ed	d.		
Box	eath certific attending p I for use as I	M/us	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy		23d. Date of delivery
O. E	iaw requires that the death certifica as been signed by the attending ph 2 should be detached for use as th	Physician/M	in the past 12 months?  1  Yes 2  No 9  Unknown  1  Other (specify)		Month Day Year
<u>α</u>	that the de ed by the detached		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death?
rds,	quires tha n signed ald be del	d by		1 🗆 Yes	2 □ No 3 □ Probably 4 No nknown
Records,	aw requir ts been si 2 should b	ompleted		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
	The ate ha	Com		performed 1 Tes 2	death?
Vital	Physician: Th this certificate ral director, pag	Be (	examiner?	h (Check only one)	and the second second
of	Phys this ral dii	. To		ome 5 Residence 28d. Describe how in	6 □Other (Specify)
On	Attending F r death. actor: After by the funer	tlon	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 8 Nork? 1 Yes 2 No		,,
Division	Atter	Certification:	a Figure 4 and 5 Could get be	28f. Location (Street City or Town, St.	and Number or Rural Route Number,
Ö	Dir.	Seri			
	ital Irs a Iral I			and due to the cause	(s) and manner as stated
	a Hospital 24 hours a Funeral I etely filled		29a. Certifler (Check only one) (Check only one) (Check only one) (Check only one)	red at the time, date a	and place, and due to the cause(s)
	To the Hospital or Attendi within 24 hours after death. To the Funeral Diractor: A completely filled in by the fu	Medical (	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	red at the time, date a	and place, and due to the cause(s)
)	To the Hospital within 24 hours of To the Funeral I completely filled	edical	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	red at the time, date a	and place, and due to the cause(s)
)	To the Hospital within 24 hours a To the Funeral I completely filled	edical	(Check only 2   Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.  29b. Signature and title of certifier  29c. License number  41658  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	red at the time, date a	and place, and due to the cause(s)
)	To the Hospital Within 24 hours a To the Funeral I to completely filled	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	red at the time, date a	and place, and due to the cause(s)

State of Maryland / Department of Health and Mental Hygiene 0 0 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 1 / 04 P2 1005 **Physician** John B. Earle III 12:10AM M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Gilchrist Nursing Center Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 54 222 - 02 - 0 958 **Funeral** Year) 05/09/1962 Director Texas John Expired 11-4-05 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show the Medical Examiner must be notified at 1 Yes 2 □ No Maryland HArford Funeral Director Havre De Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 201A Seneca Way USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: White þ 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 2 Computer Drafting KCI Technical ie marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ၉ John B. Earle Jr. Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 in any injury or othar tra QDCs. Leslie B. Fossett (fiance') 201A Seneca Way Havre De Grace, Md 21078 Baltimore, 20b. Place of Disposition (Name of cometery, crematory or other place)
West Nottingham 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State 11/09/2005 Colora, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Mitchell-Smith Funeral Home, P.A. 21. Signature of Funeral Service Licenses 123South Washington Street Havre De Grace, Md21078 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death 23a. Fart1. Enter the disease, of shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) **Physician** 1000 /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of Physician/Medical Examiner sician and burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an perfor 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 ther (Specify) 1 Yes 2 No Medicai Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 2 Accident 5 Pendina 1 ☐ Yes 2 ☐ No investigation within 24 hours after death To the Funeral Director:, completely filled in by the t 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Charles St. Balto, md In C 32 Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 2 2 2005 Registrar

			1 - For Stata Registrar	State of Mar		artment of He tificate of D		ental Hygié	_ 0 0 0	37570	
	Discrete!		1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death 8:00 P M	
	Physici /Medic	Alvin Joseph Filbert Sr. November 17 200									
	Examin		4a. Facility Name (If not institution, give s	_		4b. City, Town, or t	ocation of Death		4c. County of Death		
			306 C Canterbury  5. Social Security Number 6. Sex		(In yrs. last birthday)	Bel Air	If Under 24 Hrs.	9. Data of Birth	Harfo		
	Funeral Director			M 2□F	80 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye Oct 25,	1925 Mar	place (State or Foreign otry) Vland	
	- :		Usual Residence of Decedent					000 23,	1723 1181	y Land	
	how		10a. State 10b. County		IOc. City, Town or Lo	cation			1	Od. Inside City Limits	
	Ba-fs	cto	Maryland Harford		Be1	Air				1 ☐ Yes 2 📉 No	
	ith th or 28	Dire	10e. Street and Number	- 1		10f. Zip Code	,	10g.	. Citizen of What Cour	ntry?	
	s 23a	rai	306 C Canterbury		110	2101		-7. V	USA	and tasks	
	hours after death with the Maryland tural , or Itams 23a or 28a-f show al Examinar must be notified at	Funeral Director	11. Marital Status 1 ☐ Never Married 2 Married	<ol> <li>Was Decedent Ev Armed Forces?</li> <li>1 X Yes 2 □ No</li> </ol>		Was Decedent of His f Yes, specify Cuban	, Mexican, Puerto	Rican, etc.)	14. Race - Americ Black, White,		
336	urs aff	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1945	I□Yes 2∏ No	Specify:		Specify: Whi	.te	
21215-0036	72 hours after death with the Marylan "natural", or Itams 23a or 28a-f show idigal Examinar must be notified at	Completed	15. Decedent's Educ (Specify only highest grade		16a. Dece	tent's Usual Occupat kind of work done du	ion	161	b. Kind of Business/In	dustry	
21	within 7 ene. than "r the Med	npie	Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	OO NOT use retired)	ining most or workii	,9	a. 1 T	1	
	be filed within 72 ha tal Hygiene. d othar than "natui avant, in Medical		47. 5-16-1-16-1-16-16-16-16-16-16-16-16-16-16			Foreman	10 Martin de Nome	(Fig. 14:4 H = 14:5	Steel Inc	lustry	
Maryland	be fi	Be	17. Father's Name (First, Middle, Last) Russell Wilson Fi	1hort				(First, Middle, Mai J. Tieble			
<u>\frac{1}{2}</u>	s 1 and 2 should be if Health and Mental itam 27 is markad oothar traumatic ava	٦	19a. Informant's Name/Relationship (Typ		19b Mailir	n Address (Street ar	<u>-</u>		ity or Town, State, Zip	Code)	
Ma	01 00 00 00		Marie T. Filbert,			-			Maryland		
ē,	of Health of Health itam 27 i		20a. Method of Disposition		20b. Place of Dispo		0		c. Location - City or To		
Ë	Page nent o		1 ☐ Burial 2 🛣 Cremation 3 ☐ R.  '4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		ematory I		L8/05 B	altimore,	Maryland	
Baltimore,	permit. Pages 1 Department of H Important: If its any injury or ot once.		21. Signature of Funeral Service License	6	22	Name and Address	of Facility Society (	of Maryla	nd Inc.		
_	897		Thomas Gregor			99 Freder	ick Road	Baltimor	e, Marylar		
			23a. Part1. Enter the disease, or complications, or heart failure. List only on	eations that caused the cause on each line	ne death. Do not ent			r respiratory arrest,		Approximate Interval Between Onset, and Death	
	nysician		Immediate Cause (Final disease or condition resulting in death)	PR	VCER	14 GEAR					
	/Medical Examiner		Todaling in dealiny	Due to (or as a	consequence of):					/	
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[]	uted d ansit	Examin	Cause (Disease or injury that initiated events								
9	an an rial-tr		resulting in death) Last	Due to (or as a	consequence of);						
68760,	cate be executed physician and the burial-transit	edicai		·							
		Мес	IF FEMALE:	10 Iduan sutassa at					1		
Вох	death certific e attending p ed for use as	Physician/M	in the past 12 months?	3c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at tii	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	Day Year	
o.	0 0 0	ıysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	ne or death 3	Other (specify)					
<b>a</b>	The law requires that the tee has been signed by th bage 2 should be detache		Part II. Other significant conditions con	-	_	nderlying cause giver	n în Part I.	23e. Did tobac	co use contribute to the	ne cause of death?	
rds	quires in sign uld be	ed by	BONE ME	MSMSI	<u> </u>			1 🗆 Yes	2 No 3 Prob	ably 4 Unknown	
Vital Records,	law requir as been si 2 should	Completed						24a. Was an	24b. Were auto	psy findings available	
R	The I	mo;						autopsy performed	death?	mpletion of cause of	
ita	iclan: T Sertificat ector, pa	Be C	25. Was case referred to medical examiner?				26. Place of Death				
of V	Physiclan: this certific ral director,	2	1 ☐ Yes 2 🗷 No		2 ER/Outpatien		4   Nursing Hon		e 6 Other (Specif	y)	
n C		ion:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time of Injury	Work?	at 2 es 2 ⊡No	8d. Describe how i	njury occurred		
Division	Attendia death. ctor: A y the fu	ficat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury	y - At home, farm, str			28f. Location (Stree	t and Number or Rura	al Route Number.	
Div	after Dire	Certification:	4 Homicide determined	building, etc.		out and only		City or Town, S			
	To the Hospital or Attending within 24 hours after death.  To tha Funaral Director: Afte completely filled in by the fune		29a. Certifier 1 X Cartifying Phys	ician: To the best of	my knowledge, death	occurred at the time	, date and place, a	and due to the caus	e(s) and manner as s	tated.	
	in 24 tha Fi	Medical	one)	and manner state	ed.				and place, and due to		
	To To To To	2	29b Signature and title of certifier	10.1	/a. N	29c. License	number	,	Date signed (Month,		
	N		Joan Ca	www	(n)	001	113	100	Venser	10,2005	
	10		30. Name and address of person who co	mpleted cause of dea		USTON	DELHI	1 And	MILLE	7	
	Sta	ate	31. Date filed (Month Pay, Year) 20	32 Aegistrar	s Signature	· SI UIV	VIIIVO	r CIIV D	JIUT		
	Registi		MANGER	10 Carre	15 A	side!					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 5 37571 Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** FINK BINDER RACPH NOVEMBER 20 2005 /Medical 4b. City, Town, or Locetion of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Bultimore Center Keswick multicare N/A 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

No. 2 Yrs. Months Days Hours Min. 6. Sex\_ 1 → M 2 □ F 5. Social Security Number 8. Date of Birth (Month, Day, Year) June 13,1923 Birthplace (State or Foreign Country) **Funeral** 219-18-4853 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 ☐ Yes 2 No Funeral Director Maryland Baltimore County Lutherville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ត 107 Warwick Drive 21093 United States

14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? 1 23-Yes 2 □ No If Yes, Give Year or Dates: ₩.W.TI Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, atc. 1 Never Married 2 Married 1 Yes 2 No Specify: White δ 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) Salesman 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Peges 1 end 2 should be fill ment of Heelth end Mentel Hy ant: If Item 27 is marked oth Ralph D. Finkbinder,Sr. Roberta Everngam 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Althea Hardman (Wife) 107 Warwick Drive Lutherville, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Nov. 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 21,2005 Evans Funeral Chapel inlury 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, Maryland Peaceful Alternatives Funeral&Cremation Ctr.,P.A 2325 York Road Timonium,Maryland 21093 21. Signature of Funeral Service License s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, se on each line. Physician Immediate Cause (Final disease or condition resulting in death) /Medical UNG Cancer Months Examiner Examiner or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 □ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings avaitable prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 1 (A)Vatural 5 Pending investigation 1 Yes 2 No 2 Accident Director 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier November 20 2005 D 58303 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AANSN Charles wo bold N. Charles St Porson, MD 21204

Registrar DHMH 16 Rev 6/95

31. Date filed (Month, Day, Year) NOV 2 2

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

6601

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Neme (First, Middle, Lest) 3. Time of Death Month **Physician** Marilyn Margaret Frech Nov. 19 2005 6:40 PM /Medical 4b. City, Town, or Location of Death 4a. Fecility Neme (If not institution, give street and number) 4c. County of Deeth Examiner St. Joseph's Hospital Baltimore Towson If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Hours 1□M 2₽F Yrs. 78 215-42-6070 Director Nov. 26 1926 Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County 7 is marked other than "naturel", or items 23e or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Director Baltimore Cockeysville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? #306 300 International Circle 21030 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 ☐ Yes 27 No If Yes, Give 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify. Completed by 3 ☐ Widowed 4 ☐ Divorced white 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Peges 1 and 2 should be filed withir Depertment of Health end Mental Hygiene. Important: If item 27 is merked other than eny injury or other traumatic event, the Ms Elementary/Secondary (0-12) College (1-4or 5+) n/a Secretary Fraternal Organization 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Anthony Sardillo Carrie Britton ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Morley Frech, Sr./husband 300 International Circle, Cockeysville, MD 21030 20b. Place of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) akesville Memorial 11/23/05 Sykesville, MD 22. Name end Address of Facility 21. Signature of Funeral Service Lemmon Funeral Home of Dulaney Valley, 10 W. Padonia Rd., Timonium, MD 21093 Michael . Flagle 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as e consequence of): Examiner the attending physician end hed for use es the burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in deeth) Lest Due to (or as e consequence of): Physician/Medical Due to (or as e consequence of): Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24a. Was en eutopsy performed? Completed 1 ☐ Yes 2 No 1 ☐ Yes 2 ☑ No Vacemale Be 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☑ No ٩ After this 28a. Date of Injury (Month, Day Yeer) 27. Manner of Death 28c. Injury et Work? 28d. Describe how injury occurred Certification: or Attending 5 Pending investigation 1 Naturel s efter death.

I Director: Aft
d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide To the Hospital or within 24 hours eff To the Funerel Di 1 Certifying Physicien: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) end menner es steted.

2 Medical Exeminer: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner steted. 29a. Certifier Medicai (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 11-21-05 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) Ballo, Md 21224 L/Berto 800 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2005

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item 12 per fth 8849 11-22-05 Mental Hygiene 0 5 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year 9:46 PM Foster 2005 Edward 11 November 4b. City, Town, or Location of Death 4c. County of Death N/A 4a. Facility Name (If not institution, give street and number) 0 Jahr rear Birthplace (State or Foreign Country) Social Security Number . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Hours Min 1**⊠**M 2□F 248-48-0925 Yrs. March 8,1933 S.Carolina Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits N/ABaltimore Maryland XXYes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21206 5813 Judith Way USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Pyes School If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married Black 1 ☐ Yes 2 ☑ No Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10th grade Steelworker Bethlehem Steel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas Foster May Graves 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Foster/ Wife 5813 Judith Way Baltimore, Maryland 21206 Ella 20b. Place of Disposition (Name of 11/02t4/05 20c. Location - City or Town, State 20a. Method of Disposition Baltimore National Cemetery Baltimore, Maryland 1 ABurial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Furieral Service Licensee 5240 Reisterstown Rd Baltimore, Md 21215 23a. Part1. Erfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ediate Cause (Final Aspiration Preumonia 5days disease or condition resulting in death) Due to (or as a consequence of): Cancer Metastatic 3 years Luna Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes 2⊡ No 25. Was case referred to medical 26. Place of Death Check only one examiner Hospital: 1 Anpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 PNatural 5 Pending Injury 1 Tes 2 No 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

/Medical Examiner Examiner ed by the attending physicien and detached for use es the burial-tran Physician/Medical been signed be should be deta þ Completed certificate has : After this certification, Be ٩ Certification: death. Director: cai

**Physician** 

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

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**Funeral** 

Director

with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: if item 27 is marked other then "natural", or fleme 23s or 28s-1 show any njury or other traumatic event, the Medical Exertit and must be notified at once.

Baltimore, Maryland 21215-0036

Hospitel or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, 24 hours after o within 2 the

> PERTRICK 31. Date filed (Month, Day, Year) State

29a, Certifier (Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SOSNEY

Johns Hopkins Hospital 32. Registrar's Signature NOV 2 2 2005 1 stal

MD

dista

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

601

29c. License number

D0061889

North

29d. Date signed (Month, Day, Year)

Wolfe Steat

November 12,2005

MD 21287

Baltimore

Registrar

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			For	State of	Marylan	d / Depa	ırtmeni	of H	ealth a		_	giene	005	37574
		_]	State Registrar			Cer	tificate	e of L	Jeath	- 1		Reg. No.	000	
	Physicia		1. Decedent's Name (First, Middle,								2. Date of De Month Novembe	Day	, 2005	3. Time of Death  11:00 P.M
	/Medica	ai -	John Martin Fry  la. Facility Name (If not institution,		nher)		4b. City.	Fown, or	Location of		MOVEMBE		County of Dea	
	Examine	er '	14405 Barkwood		.50.7		Rock						ntgome	
	Funeral			Sex	7. Age (In yrs. I	ast birthday)	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da April	th v. Year)	9. Bir	thplace (State or Foreign ountry)
	Director		102-24-8284	1 <b>∑</b> M 2□F	73	Yrs.	Months	Days	Hours	IVIIII.	April	26, 1	932 New	York
	pu »	- }-	Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside City Limits
	Aaryla I sho			mo ru		ockvil								1 ☐ Yes 2 No
	28a-	0	Maryland   Montgo	шегу		OCKVII	10f. Zip	Code				10g. Citi:	zen of What C	ountry?
	N with		14405 Barkwood I	)rive			20	853				Unit	ed Sta	tes
	ems ser ma	iner	11. Marital Status	12. Was Dece Armed Fo	dent Ever in U.	S. 13.	Was Deced	lent of Hi	spanic Ori n, Mexicar	gin? (Spe n, Puerto	ecify Yes or No Rican, etc.)	)·	<ol> <li>Race - Am Black, Whi</li> </ol>	
36	or it	Completed by Funeral	1 ☐ Never Married 2 🔀 Marrie 3 ☐ Widowed 4 ☐ Divorced	If Yes, Giv	e		1 ☐ Yes	2 🕅 No	Specify:				Specify.Wh i	te
Ö	tural'	ed b	15. Decedent's	Year or Da	ates.	16a. Dece	dent's Usua	I Occupa	ation			16b. Kir	nd of Business	s/Industry
15	nin 72	plet	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1	-4or 5+)	(Give	kind of wor DO NOT us	rk done d se retired	during mos I)	t of work	ing			mmunications
212	d with giene ar tha	E C	Liententary/Secondary (0 12)	5-		Admir	nistra	ativ					ommissi	on
nd	ould be filed within 72 hours after death with the Maryland Mental Hygiene.  arked other than "natural", or items 23a or 28a-f show atte event, the Maryleal Examiner must be notified at	Be	17. Father's Name (First, Middle, La								e (First, Middle		Sumame)	
yla	should I	ပ္	Nicholas Frysia			10h Maili	a Addross	/Stroot			ne Kali al Route Numb		r Town State	Zin Code)
Mar	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-1 show or other traumatic event, the Modical Examines must be notified at		19a. Informant's Name/Relationshi Frances Frysiak								Rockvi			
e,	Healt Healt tem 2 other	1 }	20a. Method of Disposition		20b. F	Place of Dieno	eition /Nar	ne of	1		Date nber 21,		cation - City o	
OL	Pages ent of nt: if i		1 ☐ Burial 2 ☐ Cremation : 4 ☐ Donation 5 ☒ Other (Sp.	B⊟Removal from BoifEntombm	State Ga ent M	te of ausole	Heáve	n	i	200	05	Silve:	r Spring	, Maryland
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tra	1	21. Signat re i Funeral Service L			Ro	Name ar	1Addre	Inc.	yRob 6	ert A. West A	Pumpl lonte	omery Fu	ineral Home/ Avenue
	20 E 6 0		23a. Part1. Enter the disease, or c	omplications that of	M01353									Approximate
			shock, or heart failure. List o	nly one cause on e	ach line.	551151 511			3,		,			Interval Between Onset and Death
	Pnysician /Medical	1	disease or condition resulting in death)	a	monia (or as a conseq	uence of):								Acute
П	Examiner		and the second second		trophic		al Sc	lero	sis					Months
7	P =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury	Due to	(or as a conseq	uence of):								
V	be executed Ician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	(or as a conseq	uence of):								
760,	be executed sloian and burial-transit	calE			(01 40 4 0011004	30.133 3.7.								
687	w > w			0.								10		
Вох	The law requires that the death certification has been signed by the attending phy bage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant		tcome of pregna		□Ectopic p	rennancy	,				23d. Date of de	
	death	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No		nant at time of c		Other (sp						Month	Day Year
P.0	that the de ned by the detached	Phy	9 Unknown  Part II. Other significant condition			ulting in the I	inderhing (	Salice div	en in Part		23e. Did	tobacco u	se contribute	to the cause of death?
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Records,	w require been si should I	Completed		et son hy							24a. Wa	s an	24b. Were a	autopsy findings available
Rec	The law ate has page 2:	mp	Prostatic Hype	гсгорну							auto	opsy ormed?	prior to death?	completion of cause of
Vital		e Co	25. Was case referred to medical						26. Plac	e of Deat	1 ☐ Yes		1016	35 2 140
>		O B	examiner? 1 ☐ Yes 2 💢 No	Hospital: 1 🔲	Inpatient 2	ER/Outpatie	nt 3 🗆 D	OA Oth	ler: 4 □ N	ursing Ho	ome 5 🔀 Res	sidence	6 □Other (Sp	pecify)
J Of	ding Phys	n: T	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date (Mor	of Injury oth, Day Year)	28b. Time o	of :	28c. Injur Wor			28d. Describe			
Sion	Attending Ph r death. ector: After th by the funeral	catic	2 Accident investig	ation			М		Yes 2	]No	ORE Leasting	/Ctront an	al Miranhas as i	Ouml Coute Number
Division	or Att	Certification:	3 Suicide 6 Could n 4 Homicide determi	ned 289. Place	e of Injury - At h ling, etc. <i>(Speci</i>	iome, farm, st fy)	reet, factor	y, office				own, State		Rural Route Number,
J	To the Hospital or Attendwithin 24 hours after death To the Funeral Director:		29a. Certifier 1 X Certifyin	g Physician: To the	e best of my kn	owledge, dea	th occurred	at the ti	me, date a	nd place,	and due to the	e cause(s)	and manner	as stated.
	ne Hoon 24 h	Medical	(Check only 2 Medical l	xaminer: On the b and mar	pasis of examination of stated.	ation and/or ir	nvestigation	n, in my c	pinion, de	ath occur	red at the time			
	Withir To the Comp	×	29b. Signature and title of certifier	2 M					e number					nth, Day, Year) 7 , 2005
			Proglas					)2730	) T			MOVE	mber 1	, 2003
	12		30. Name and address of person to Douglas R. Shum	who completed cau	se of death (Ite	m 23a) (Type	, Print)	meru	Δποτ	1110	Rockwi	116.	MD. 20	850
	10	ate.	- " " " " " " " " " " " " " " " " " " "		O I - I - O	-4			214 61	,	TO CHEV I	,	-12. 20	
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ORIGINAL

	1	For State Registrar	State of Ma	ryland / Depa <i>Cei</i>	artment of H <i>rtificate of L</i>			glegen 05	37576
Physicia	n	. Decedent's Name (First, Middle, L		BURNELL	GARRETT		2. Date of Dea Month NOV • 2	Day Year	3. Time of Death 9:00 A M
/Medica Examine Funeral Director	r 4		CAL CENTE	R a (In yrs. last birthday) 71 Yrs.	WESTMIN	STER If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Da) 9 / 2 1 / 1	4c. County of De CARRO 9. B ( 934 MA	
D		Usual Residence of Decedent 10a. State 10b. County	ГТ	10c. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 No
vith the Ma t or 28a-f s	<u> </u>	MD CARRO			10f. Zip Code 2115	7		10g. Citizen of What 0	Country?
Iryland 21215-UUSD should be filed within 72 hours after death with the Maryland and Mental Hygiene. marked other than "natural", or items 23a or 28a-f show marked other than "natural", or items 23a or 28a-f show imatic event. The Madical Example rount be notified at	by Funeral	3070 MARSTON ☐  11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ☒ Divorced	12. Was Decedent 8 Armed Forces? 1 ∑ Yes 2 □ N	MKODE X M	Was Decedent of Hi If Yes, specify Cuba		ecify Yes or No- Rican, etc.)	14. Race - An Black, Wh	nerican Indian, nite, etc.
within 72 hours at ene "natural", or than "natural", or the Medical Exemple	Completed	15. Decedent's (Specify only highest g	Education	16a. Dece (Give life.	odent's Usual Occupa e kind of work done of DO NOT use retired	turing most of work )	ing	16b. Kind of Busines HOME IMPROVEN	,
IDG 21 be filed wi tal Hygien d other th	Be	1 2 17. Father's Name (First, Middle, La		J.		18. Mother's Nam		Maiden Sumame) A. RICH	ARTS
Maryland d 2 should be file th and Mental Hy it is marked othe traumatic event	၉	19a. Informant's Name/Relationship			ing Address (Street	and Number or Rui	al Route Numbe	er, City or Town, State	, Zip Code) 21157
Baltimore, Marylar permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic as once.	- 1	BARBARA E. WAN  20a. Method of Disposition  1 ☐ Burial 2 ☑ Cremation 3  1 ☐ Donation 5 ☐ Other (Spe	☐Removal from State	20b. Place of Disp	osition (Name of	101	Date	20c. Location - City	or Town, State
Baltir permit. P Departme Importan any injur		21. Signature of parservice Lie						FUNERAL INSTER,	HOME MD. 21157
Physician	· Ji	23a. Part 1. Enter the disease, or conshock, or heart failure. List on Immediate Cause (Final disease or condition	mplications that caused by one cause on each ling a. SEPS	the death. Do not enne.	nter the mode of dyin	g, such as cardiac	or respiratory a	rrest,	Approximate Interval Between Onset and Death
/Medical Examiner	<u>.</u>	resulting in death)  Sequentially list conditions, if any, leading to immediate	b	a consequence of):					
icate be executed physician and s the burial-transit	al Examiner	Cause. Enter Undertying Cause (Disease of injury that initiated events resulting in death) Last	С.	a consequence of):					
BOX 6 ath certif	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify) _	,		23d. Date of Month	delivery Day Year
ds, P.O. I	by	Part II. Other significant condition  DEMENTIA	s contributing to death b	out not resulting in the	underlying cause giv	ren in Part I.		_	e to the cause of death?  Probably 4 □Unknown
age age	ompleted	BASAL CEL	L CA	of rei	FT SHO	ULDER	24a. Was auto perfo 1 \( \text{Yes}		
of Vital Physician: This certifica	o Be C	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1 ☐ Inpati	ent 2 1 Coutpati	ent 3 DOA Oth	26. Place of Dea		one)	Specify)
ion of ading Physath. r: Atter this ie funeral di	H-	27. Manner of Death  1 Natural 5 Pending 2 Accident investiga	28a. Date of Inju (Month, Da	ury 28b. Time	of 28c. Inju		28d. Describe	how injury occurred	
Division tal or Attendir s after death. al Director: At	Certification:	3 Suicide 6 Could no 4 Homicide determin	ad 200. Place of in	jury - At home, farm, s tc. <i>(Specify)</i>	street, factory, office		28f. Location ( City or To	'Street and Number or wn, State)	Rural Route Number,
Division  To the Hospital or Attending within 24 hours after death.  To the Funeral Director: Attention to the Funeral Director: Attention to the fune fune fune fune fune fune fune fun	Medical	(Check only 2 Medical E	Physician: To the best xaminer: On the basis of and manner s	of examination and/or	ath occurred at the ti investigation, in my o	opinion, death occu	, and due to the rred at the time,	cause(s) and manner date and place, and 29d. Date signed (M	due to the cause(s)
To T com	2	29b. Signature and title of certifier	عر	M-0.	20	05458		11/20/2	1005
211		30. Name and address of person w WASTM FAKIMM, N	1.0. 417				TANEYTO	CM, KW	21787
Sta Registi		31. Date filed (Month, Day, Year)	2 2 2005	trario Signature	: Spork	,			

		1	For State	i ica.	State	of Mary		epartmer Certificat			and M	ental Hy	giene	05	37577
			Registrar  1. Decedent's Name	(First, Middle	, Last)			2011/1041				2. Date of De.	ath		3. Time of Death
	Physicia /Medic	an al		IN LeR	OY GROV			4b. City.	Town, or	Location of	of Death	Month Novemb	Day er 20.	Year 2005 Junty of Dea	12:35P M
	Examin	er '	GENESIS I				AT.							N/A	
	Funeral		5. Social Security Nu	-	6. Sex	7. Age (li	n yrs. last birth	Months		ore Ci	24 Mrs. Min.	8. Date of Bird (Month, Da	th y, Year)	9. Bir	thplace (State or Foreign ountry)
	Director		216-30-0		11 1 1 2 □	F	69 Y	rs.				Jul 17		Ma	aryland
	and w	-	Usual Residence of E 10a. State	10b. County		10	c. City, Town	or Location							10d. Inside City Limits
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	h the	Directo	10e. Street and Num	per					Code				10g. Citizer	n of What Co	ountry?
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	ar dea	Funeral	11, Marital Status	d ON More	Ame	Decedent Eve d Forces?	r in U.S.	13. Was Dece If Yes, spe	dent of Hi ecify Cuba	ispanic Ori in, Mexicar	gin? (Spe 1, Puerto	ecify Yes or No Rican, etc.)	- 14.	Black, Whi	erican Indian, te, etc.
396	filed within 72 hours aftar death with the Maryland Hygiene. Ithy than "natural", or tlams 23a or 28a-f show ant, the Madreal Examinating the motified at	Þ	1 ☐ Never Marrie 3 ☐ Widowed 4		I IT Y OS	es 2 MNo s, Give or Dates:		1 🗆 Yes	2 No	Specify:			Sp	pecify:	White
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auc	d be f ental l ked of	To Be	Arthur			Δ.				M-	inni	Virgi	nia H	orton	
Maryland 21215-0036	shou and M s mar umati	-	19a. Informant's Nar				19b.	Mailing Addres	s (Street			al Route Numb			Zip Code)
Σ	and 2 salth a n 27 is		LaVerne M		e (Wife	)	60	9 High	boow	Drive	e, B	ltimor	e, Mai	rylan	21212
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours aftar death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked othar than "natural, or thams 23a or 28a-f show any nurry or other traumatic event, the Medical Examinat nust be notified at any nurry or other traumatic event, the Medical Examinat nust be notified at annex.		20a. Method of Dispo	Cremation			cemetery	, crematory or	other plac	:ө)					
<u>=</u>	it. Pa rtmen rtant: njury		' 4 Donation				Dulane	22 Name s	nd Addres	es of Facili	tv	STORY POST OF THE PARTY OF THE			, Maryland
Ba	permi Dep impo any		21. Signature of Fur Mart	in D.	Lawson	الحا		Mitch	ne11-	Wiede	feld	Funer	al Hon	ne, In	01010
			23a, Part1, Enter th	e disease, or	complications to	hat caused the	e death. Do n	ot enter the mo	de of dyin	ng, such as	cardiac	or respiratory a	rrest,	. утапа	
	Physician		Immediate Cause (I	Final	-	mehr	0000	alla	10 _	-a(	cic	Quit			Onset and Death
	/Medical Examiner		resulting in death)		1	e to (or as a c	onseque								
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Γ	uted 1 ansit	Examiner	Sequentially list con if any, leading to im- cause. Enter Under Cause (Disease or i that initiated events	rlying njury	1	150	heli	0							
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8760,	cate by	dical			d					-					
89 x	certifii ding p	/Me	IF FEMALE: 23b. Was decedent	progrant	23c. If yes	s, outcome of	pregnancy						23	d. Date of de	elivery
. Box	that the death certifica ed by the attending ph detached for use as th	Physician/Med	in the past 12 t	months?	4□i	ive birth 2		3 ☐Ectopic 5 ☐ Other (:		y 				Month	Day Year
P.O.	at the by th stache	hys	9 ☐ Unknown			Unknown		46		in Dont		220 Did	tobacco use	contribute	to the cause of death?
	law requires that the as been signed by th 2 should be detache	by	Part II, Other signifi	icant conditi	ons contributing	to death but	not resulting in	the discensing	cause giv	ren in Fast			Yes 2		Probably 4 hknown
Records,	s beer shou	ompleted										24a. Was		24b. Were a	autopsy findings available ocompletion of cause of
	0 5 0											perfe	ormed?	death?	
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of \	Phyeician: r this certific ral director,	2	1 Yes 2 2	<b>X</b> 0	Hospital:	1 Inpatient Date of Injury	2 ER/Out		OQA	and the second second	ursing Ho	ome 5 Res 28d. Describe			ecify)
	ling After funer	tlon	1 V atural	5 Pendii invest	ng	(Month, Day)		ijury M	28c. Injur Wor 1 🗆	rk? ]Yes 2.⊑	]No		,,,,,,		
Division	Attending r death. actor: Afte by the fune	ifica	3 ☐ Suicide 4 ☐ Homicide	6 Could determ	not be 28e.	Place of Injury	/ - At home, fai	m, street, facto	ory, office				(Street and a	Number or F	Rural Route Number,
á	tal or rs afte al Dira ed in I	Certification:	4   Homicide	/		building, etc.	(Орвспу)			S. S. S			,		
	To the Hospital or Attenc within 24 hours after death To tha Funaral Diractor: completely filled in by the	edical	29a. Certifier (Check only one)	1 Certifyi 2 ☐ Medical		To the best of the basis of e I manner state	xamination and	, death occurre d/or investigation	d at the ti	me, date a opinion, de	nd place, ath occur	and due to the red at the time	cause(s) a date and p	nd manner a place, and du	as stated. ue to the cause(s)
	To the within 2 To tha comple	Me	29b. Signature and	title of certifie		$\sim 0$	00.	2	9c Licens	se number			29d. Date	signed (Mor	nth, Day, Year)
	- > - 0			200	upk	26K	uly		VH	761	14		NOV	21-	05',
	5		30. Name and addr	ess of person	who ompleted	d cause of dea	ith (Item 2 a) (	Type, Print)			. 1	-			
	J		VIJAYA 31. Date filed (Mon		II REDDY	M.D.	, 821 1 s Signature	I. Euta	w St.	., Su	ite :	312, Ba	1timo:	re, M	)
: 6	St Regist	ate rar	1		2 2005	12818.	, B.	EPRIL	9			312, Ba			

UNK, UNK 05-07736		State of Maryland / Department of Head State of Maryland / Department of Head State Amend Item 1&Unpend Item 23a, 2, 28a-f per Senistrar	alth and Me me <sub>h</sub> G850 1	ntal Hygi 12-7-05	iene tas 05	37578			
CT	100	1. Decedent's Name (First, Middle, Last)		Date of Deat		3. Time of Death			
Physicia	an	Nichole Marie Geiselman	N	Month Tovember	Day Year	MA I			
/Medic		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Lo		O V Carrie	4c. County of De.				
Examili	C.	2803 Orleans Street Baltimor	re						
Funeral		5. Social Security Number 6. 3ex Months Days	Hours Min.	Date of Birth (Month, Day,	Year)	rthplace (State or Foreign Sountry) Maryland			
Director		217-06-4927 1 M 2XDF 21 Yrs. Usual Residence of Decedent		Marchi	0,1904	Maryrand			
land land		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits			
Mary II-I ●h	tor	MD Baltimore Middle River				1 □ Yes 2Ã No			
th the	Director	10e. Street and Number 10f. Zip Code	•	1	0g. Citizen of What (	Country?			
death with the Maryland me 23a or 28a-f show		11 Cutter Cove Court 212		tu Van ar Na	USA 14. Race - An	perican Indian			
er de	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married  1 Yes 2 No	Mexican, Puerto Ric	can, etc.)	Black, Wh	nite, etc.			
D36	þ	If Yes, Give 1 Yes 26 No 3 Widowed 4 Divorced Year or Dates:	Specify:		Specify: W	nite			
5-00	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done duri	on ring most of working	,	16b. Kind of Busines	s/Industry			
Mahin Mahin	mple	Elementary/Secondary (0-12) College (1-4or 5+) Student			School				
4 21 Higie v Hygie Thert		8th  17. Father's Name (First, Middle, Last)  18	8. Mother's Name (	First, Middle, I	Maiden Sumame)				
and be and be contained to every	To Be	Norman John Geiselman	Karen ?	Ann Os	ster				
Maryland 21215-0036 d2 should be filed within 72 hours alt this and Marall Hygiens 77 is marked other than "natural", or treumatic event, the Maralcal Exami	-	104	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) other 11 Cutter Cove Court Baltimore MD 21220						
, Ma and 2 selth a									
Baltimore, Maryland 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours atter death with the Marylan Department of Heelih and Mental Hygiene. Important: If item 27 is marked other than "naturat, or iteme 23a or 28a-1 show eny injury or other treumatic event, the Marical Examination at once.		20a. Method of Disposition  1  Burial 2 (XCremation 3 Removal from State 4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  BayviewCremator	y 11/22		20c. Location - City o Baltimor	e MD			
Balti Permit. Departri Importa			e Ave. B	Baltim	roe MD 2	omeofEssex 1221			
1 A A		23a. Part1. Enter the disease, or complications that caused the death Do not enter the mode of dying, shock, or heart failure. List only one cause on each line.	such as cardiac or	respiratory arr	rest,	Approximate Interval Between Onset and Death			
Physician		Immediate Cause (Final disease or condition  Narcotic(Heroin)Intoxication	1			Oliset and Beatin			
/Medical Examiner		resulting in death)  Due to (or as a consequence of):							
	ē	Sequentially list conditions, fany, leading to immediate							
uted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							
760, e be executed /sician and e burial-transit		resulting in death) Last Due to (or as a consequence of):							
0 0	dical	d							
x 68	/Mec	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of	delivery			
Box 687 leath certificate attending phys	Physician/Medi	23b. Was decedent pregnant in the past 12 months?  1   Yes   2   No   No   No   No   No   No   No			Month	Day Year			
cords, P.O.  requires that the de been signed by the	hysl	9 Unknown							
S, P	by P	Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given	n in Part I.			to the cause of death?			
ords				1 1 4		Probably 4 Unknown			
ecc law r las be	Completed			24a. Was a autop	sy prior	autopsy lindings available to completion of cause of			
al Rec	5			1 X Yes	2 □ No 12(Y	es 2□ No			
Vital Ficien: The certificate	Be	examiner? Hospital: Other	26. Place of Death		ne) dence 6y⊠Other(S	necify) Scope			
On of ding Phys h. After this of	7. To	unk contract			now injury occurred	unk			
ion nding ath. r: Afte	atlor	1   Natural 5   Pending   Found Day Year)   Injury   Work?   2   Accident   vinvestigation   1   1   1   1   1   1   1   1   1	es 2X No						
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physicien: The law requires that the death certificat within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as in	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify)  Found in vacant house	Bi	8f. Location (S City or Tow altimor		Orleans St.,			
Hospit. 24 hours Funera	Medical (		e, date and place, ar inion, death occurre	nd due to the old at the time,	cause(s) and manner date and place, and (	as stated. due to the cause(s)			
To the To the complex	Me	29b. Signature and title of certifier 29c. License	number		29d. Date signed (M	onth, Day, Year)			
		· Corler W OC	ME		November	17, 2005			
_		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	n Stroot	Rol+4:	more Mar	land 21201			
		at Date Hard (Month Day Year) 32 Pagistrar's Signature	TI PITEEL	חמדנדו	more, nai)	Tanu ZIZUI			
S Regis	tate trar								
DHMH 17 Rev 1	2001	NUV & G LUUS POSSESS P							

ORIGINAL

			For State Registrar	State of Mar	•	partment of ertificate of			giene Reg. No.	005	37580
			1. Decedent's Name (First, Middle, La	st)				2. Date of De.			3. Time of Death
	Physici		Richard George	Hanna				11/16/	/200	5 Year	10:00A M
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town	n, or Location of Dea	ith	4c.	County of Dea	th
			212 Granada Ro	ad		Pasa	dena		A	nne A	rundel
	Funeral		Social Security Number     6. S	ex 7. Age	(In yrs. last birthd	Months Da		s. 8. Date of Bird (Month, Da	th y, Year)	9. Bir	thplace (State or Foreign
В	Director		217-24-4585	, M ZUF	75 Yrs			05/17/	/193	30	MD
	and *		Usual Residence of Decedent  10a, State 10b, County		10c. City, Town or	Location					10d. Inside City Limits
	/anyli	5	MD Anno A	rundel	Pasad	on a					1 Yes 2 No
	28a-	Director	MD Anne A	runder	rasau	10f. Zip Cod	e		10a. Citi	zen of What Co	ountry?
	Mith Ba or	<u> </u>	212 Granada Ro	d		211				S.A.	
	ns 2:	era	11. Marital Status	12. Was Decedent Ev	er in U.S. 1	3. Was Decedent	of Hispanic Origin? (	Specify Yes or No		14. Race - Ame	
മ	filed within 72 hours after death with the Maryland Hygiene Ather than "natural", or Iteme 23a or 28a-f show ther than "natural", or Iteme 23a or 28a-f show Int, the Madical Examinar must be natilised at	Funeral	1 ☐ Never Married 2 Married	Armed Forces? 1 XYes 2 □ No	1948-		uban, Mexican, Puè	rto Rican, etc.)		Black, Whit	te, etc.
ဇ္ဇ	ral', o	호	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1952	1 ☐ Yes 2 🔀 i	No Specify:			Specify: W	hite
2 2	natur	Completed	15. Decedent's Ed (Specify only highest gra		16a. De	cedent's Usual Oc	cupation ne during most of w	orkina	16b. Ki	nd of Business	/Industry
2	ithin	g	Elementary/Secondary (0-12)	College (1-4or 5+	) life	e. DO NOT use re	tired)				
7	lygier her tr	ខ្ញុ	12		Ele	ctrical	Technic		BGE		
and	be fi	Be	17. Father's Name (First, Middle, Last)					ame (First, Middle,	Maiden	Sumame)	
3	d Mer narke	ဥ	George William		405.44	-10 4 4 4 (01-	Leburt eet and Number or F	a Ball	0.	. T Ot	T. C. 4.1
Maryland 21215-0036	12 sh h and 7 is n traun		19a. Informant's Name/Relationship (			,			. ,		
e,	Healt Healt He 2		Margaret M. Ha 20a. Method of Disposition	nna / Wif	The second second second	sposition (Name of	da Road,	Date		cation - City or	
Baltimore,	nt of		1 ■Burial 2 Cremation 3 C		cemetery, o	rematory or other	olace)	/00 /0F			
틀	it. Printme		4 □ Donation 5 □ Other (Specification 21. Signature of Funerat Service Licer		Cedar	Hill Ce 22. Name and Ad		/22/05			
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show amportant: or other traumatic event, the Madical Exemitiar main the notified at QDGs.		21. Signature of Fusion Service Literature	1300			iera Dri				1 Home, PA D 21122
			23a. Part1. Enter the disease, or comshock, or heart faiture. List only	plications that caused to one cause on each line	he death. Do not	enter the mode of	tying, such as cardia	ac or respiratory ai	rrest,		Approximate Interval Between
1	Physician		tmmediate Cause (Final disease or condition	. CAL	ZCINC	AMO	YAN C	REAS			Onset and Death
	/Medical Examiner		resulting in death)		consequence of):						
	LAGITITICI		Sequentially list conditions,	b	consequence of).						
	led isit	lne	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Dus to (ci as a	consequence or).						
	ficate be executed physicien and is the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a	consequence of):				_		
8760,	sicier b buri	dlcal		đ							
289	ificate g phy as the	0		0.							
Вох	eath certific ettending p I for use as	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		n () e			2	23d. Date of de	livery
œ.	The law requires thet the death certifi ate hes been signed by the ettending page 2 should be detached for use as	Physiclan/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 4 Pregnant at ti		3 ☐ Ectopic pregna 5 ☐ Other (specify	)			Month	Day Year
Ö.	t the by th tache	hys	9 Unknown	9□ Unknown							
S, D	eb eq	by P	Part It. Other significant conditions of	contributing to death but	not resulting in th	e underlying cause	given in Part f.	23e. Did to	obacco u	se contribute to	the cause of death?
Ž	v requir been si should I	ed						1 🗆 '	Yes 2[	□No 3□Pi	robably 4 Unknown
ecc	law r es be 2 sh	Completed						24a. Was		24b. Were au	utopsy findings available completion of cause of
œ	The late he page	МO						perfo 1 ☐ Yes	rmed?	death?	2 □ No
ita	iysician: Th iis certificate director, pag	Be	25. Was case referred to medical examiner?		-			eath (Check only o			
<u>&gt;</u>	× 200	၉	1 Yes 2 No	Hospital: 1   Inpatient	t 2 ☐ ER/Outpa	tient 3 DOA	Other: 4 Nursing	Home 5 Resid	dence (	6 □Other (Spe	city)
ב	ding Pth I. After th funeral	ü	27. Manner of Death  1. Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Tim	ry \	njury at Work?	28d. Describe I	now injur	y occurred	
sio	Attending or death. ector: After by the fune	cat	2 Accident investigation 3 Suicide 6 Could not b	е			Yes 2 No				
Division of Vital Records,	for Attendation after death Director:	Certification:	4 Homicide determined			street, factory, offi	ce	City or Tov			ural Route Number,
	ospita hours uneral ly fillec		29a. Certifier 1 Certifying Pt	nysician: To the best of	my knowledge, d	eath occurred at the	e time, date and place	ce, and due to the	cause(s)	and manner as	s stated.
	To the Hospital or Attending I within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Medical	29b. Signature and title of certifier	miner: On the basis of e and manner state	d.		ense number			e signed (Mont	
	F ≯ F 8		Pacho	elt.	R		DO 75		3	EMB	
ı	5/	>	30. Name and address of person who	completed cause of dea	ath (Item 23a) (Ty	pe, Print)	/	^		0	11
1	041/		RICHARD & 1	FISHER	MD	(RAIN	10WEV	25 (01	EN	SURIU	EMD
	Sta		31. Date fifed (Month, Day, Year)	32. Registrar	's Signature	14 600	TOWEV				
	Registi	ar	NO	V 2 2 2005	METERS	~ 1	4.00				

		•	For State Registrer	State of Mar	-	epartment of H Certificate of L			iene g. Wo. 0 5	37581
	Physici		1. Decedent's Name <i>(First, Middl</i> e, Las Viola Mae		n			2. Date of Deat November		3. Time of Death 7:30 pM
To the second	/Medic Examin		4a. Facility Name (If not institution, give	,	<del> </del>	4b. City, Town, or Joppa	Location of Death		4c. County of Harfo	
	Funeral Director		5. Social Security Number 6. Se		In yrs. last birtho	Months Davs	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Jan 29,	Year)	Birthplace (State or Foreign Country) Virginia
	and w		Usual Residence of Decedent  10a, State 10b, County		IOc. City, Town o	r Location				10d. Inside City Limits
	Maryli -f eho	tor	Maryland Harford		Joppa					1 ☐ Yes 2X No
	h with the	al Directo	10e. Street and Number 1019 Old Joppa Ro	pad		10f. Zip Code	21085	1	og. Citizen of Wh	at Country? SA
386	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or iteme 23s or 28s-f ehow enty highly or other traumatic event, the Medical Examinant must be inclined at once.	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	er in U.S.	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	ispanic Origin? (Sp in, Mexican, Puero Specify:	ecify Yes or No- Rican, etc.)		American Indian, White, etc. White
2-0	"nature	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a. D	ecedent's Usual Occupative kind of work done of	ation during most of work	king	16b. Kind of Busi	ness/Industry
2121	iene. r then	omp	Elementary/Secondary (0-12)	College (1-4or 5+)		Seamstress	,		Clothin	g MFG.
Maryland 21215-0036	d be filed antal Hyg ted other c event,	Be	17. Father's Name (First, Middle, Last) Joseph F. Hall		·			e (First, Middle, M Belle Ha	Maiden Sumame) ale	
ary	should and Me smark umati	오	19a. Informant's Name/Relationship (7	Type, Print)		failing Address (Street				
Z,	and 2 ealth a m 27 ii		Debra L. Bengtson	(daughter)		75 Ebenezer isposition (Name of				21220 ity or Town, State
Baltimore,	Pages 1		20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specify	)	cemetery,	crematory or other place ill Mem. Ga	rdens 11	/21/2005	Baltimo	re County, Md.
Bai	permit Depar Impor eny In		21. Signature of Fundral 5 Mas Loan	\$99		22. Name and Address 1407 Old E				
<i>(*</i> :	Physician /Medical Examiner		23a. Part1. Enter the disease, or compshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions.	a	consequence of	:	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
4	acuted and transit	Examiner	ill any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.						
8760,	icate be executed physician and s the burial-transit	dlcal Ex	rosaning in odality Edist	d.	consequence of)					
P.O. Box 6	Physicien: The law requires that the death certific this certificate has been signed by the attending p ral director, page 2 should be detached for use as	by Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at ti	Fetal death	3 □Ectopic pregnancy 5 □ Other (specify) _			23d. Date Monti	,
	uires that n signed b		Part II. Other significant conditions of	ontributing to death but	not resulting in t	he underlying cause giv	en in Part I.	\/		ute to the cause of death?
Vital Records,	ysicien: The law requir is certificate has been si director, page 2 should	Completed		(		/		24a. Was a autops perform	nted3 de	ere autopsy findings available or to comptetion of cause of ath?
Vita	sicien: certific rector,	o Be	25. Was case referred to medical examiner?	Hospital:	00000	Oth	er	th (Check only on		(0
of	ding Phys h. After this funeral di	<b>-</b>	1 Yes 2 No 27. Manner of Death	1 Inpatien  28a. Date of Injury (Month, Day	28b. Tir	ne of 28c. Injur		ome 5 Reside	ow injury occurred	1
Division of	tendin death. tor: Af the fur	catlo	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	1		M 1 🗆	Yes 2 □ No	29f Logation (St	root and Number	or Rural Route Number,
Ω	al or A s after at Direct	Certification:	4 Homicide determined	building, etc.	(Specify)	n, street, factory, office		City or Town		or ribrar rioble runnbor,
	Hospit 4 hour Funera	edical	29a. Certifier 1/2 Certifying Ph	ysicien: To the best of	my knowledge,	death occurred at the tir	ne, date and place	, and due to the ca	ause(s) and mani	ner as stated.
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Med	29b. Signature and title of certifier	and manner state	W 1	29c. Licens				(Month, Day, Year)
,	3		30. Name and address of person who	completed use of de	ath (Item 23a) (T	yoe, Print)	Davo -	D - 11.	11/2/	102122
	% - % St	ate	31. Date filed (Month, Day, Year)	32 Registrar	's Signature	KO(35)	Ka,	nevym	100 11	WULLA
	Regist	Idl	NOV 2 2 20	UJ DESERVE	20 14					

		1	= For State Registrar Amend Item #	State of Ma	nyland/Dep \$26 \$19a Per <sup>C</sup> f	artment of F	lealth and B <b>eath</b> 19/	06 JH 2. Date of De	Reg. No.	3 7 5 8 2
Fan Fan A	Physicia /Medic Examin	al -	F1orence Ia. Facility Name (If not institution, give st 15820 Aitcheson Lane		rlinger	Laure1	r Location of Dea		Day Year 28 200!  4c. County of Dea Montgo	th
	uneral irector		214-20-3606	7. Ag	99 Yrs. last birthday	Months Days	If Under 24 Hrs Hours Min	. (Month, Da	9. Bi y, Year) Dist	thplace (State or Foreign ountry) rict Columbia
Maryland	-f show		Usual Residence of Decedent  10a. State 10b. County  Maryland Prince Geor	ges	10c. City, Town or L	ocation Chever1y				10d. Inside City Limits
h with the	23e or 28e at be noti	al Direc	10e. Street and Number 15820 Aitchesen-Lane 2	802 Cheve	erly Ave.	10f. Zip Code 2 <del>07</del> 6	<del>)7</del> 207	785	10g. Citizen of What C United State	
<b>5-0036</b> 72 hours after death with the Maryland	Department of Health and Mental Hygelical institutell, or Iteme 23e or 28e-f show importent: If Item 27 is marked other than "natural", or Iteme 23e or 28e-f show eny injury or other traumatic event, the Medical Examinar must be notified at once.	Completed by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 MWidowed 4 Divorced	2. Was Decedent Armed Forces? 1 ☐ Yes 2 1 1 If Yes, Give Year or Dates:	Ever in U.S. 13	. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 No	dispanic Origin? ( an, Mexican, Pue Specify:	Specify Yes or No rto Rican, etc.)		
21215-0036 od within 72 hours aft	pene. r than "natur in Medical	ompleted	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12	ation completed) College (1-4or 5	(Giv life.	edent's Usual Occup e kind of work done DO NOT use retire Bookkeeper	during most of we	orking	16b. Kind of Busines: Governmen	
Maryland 2	Mental Hyg Irked other Itic event,	To Be C	17. Father's Name (First, Middle, Last) Charles Meyer				18. Mother's Na Mary		Maiden Surname)	
Mary	alth and 1		19a. Informant's Name/Relationship (Type Dauchter Susan Jendrek/ <del>Mether</del>	рө, Print)		ling Address <i>(Street</i> O Aitcheson		rel, Maryl		
Baltimore,	nent of He int: If Item iry or oth		20a. Method of Disposition 1 ★ Burial 2 □ Cramation 3 □ Re 4 □ Donation 5 ☑ Other (Specify)	emoval from State		position (Name of ematory or other pla In Little C		Date 3-2005	20c. Location - City o Brentwood, Ma	
Balti permit.	Departri Importe eny Inju		21. Signal In Furnal Service License	Wen.			Spring Rd.		aryland 2070	7
	ysician Medical		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Multiple	e System Orga		ng, such as cardi	ac or respiratory a	rrest,	Approximate Interval Between Onset and Death 1 month
60, C	he burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	Advanced Due to (or as	a consequence of):  d Age a consequence of): a consequence of):					
ecords, P.O. Box 687	by the attending phitached for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	3c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal death 3	B Ectopic pregnanc	y		23d. Date of d Month	elivery Day Year
rds, P.	gned eb ec	δ	Part II. Other significant conditions con Hypertension	tributing to death t	out not resulting in the	underlying cause g	ven in Part I.		tobacco use contribute Yes 2∰No 3∏I	to the cause of death?  Probably 4 □Unknown
The The	ate has been si page 2 should b	Completed						24a. Was auto perfi 1  Yes	ormed? death?	
f Vita ysician:	is certifical director, p	To Be	25. Was case referred to medical examiner?  1  Yes 2 No	lospitaf: 1 ☐ Inpati	ent 2 ☐ ER/Outpati	ent 3□DOA		eath Check only Home States		Daughter's
vision of Vita	death. ctor: After th y the funeral		27. Manner of Death 1 ☒ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Da	ury 28b. Time uy Year) Injury	/ Wo	iry at ork? ] Yes 2 □ No	28d. Describe	how injury occurred	
Divis	s after de el Directo ed in by tl	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined		jury - At home, farm, tc. (Specity)	street, factory, office			(Street and Number or wn, State)	Rural Route Number,
Hospitel	within 24 hours after of To the Funeral Direct completely filled in by	Medical	29a. Certifier 1 \(\infty\) Certifying Physical (Check only one)	sician: To the best ner: On the basis of and manners	of examination and/or	ath occurred at the investigation, in my	ime, date and pla opinion, death oc	ce, and due to the curred at the time	cause(s) and manner date and place, and d	as stated. ue to the cause(s)
To th	withir To th comp	M	29b. Signature and title of gentler	v	•	29c. Licer D2.54	ise number 13U		29d. Date signed (Mo 11/21/2005	nth, Day, Year)
	10		30. Name and address of person who co John Margolis 13952 B		death (Item 23a) (Typ		707			
1,30	Sta Regist		31. Date filed (Month, Day, Year) NOV 2 2 20	32. Bagist	rar's Signature	parte				

		,	For State Registrar	State of N		d / Depa		of H	ealth a		-		ริกก		37583
	Physici /Medio Examin		1. Decedent's Name (First, Middle, Shirles 4a. Facility Name (If not institution, Levindale Ge	dueben give street and number	)Hosp	ital	4b. City,		Location of	of Death	2. Date of D Month	nbe	ay LC <u>J</u> Ü c. County		3. Time of Death 5 110 P M
	Funeral Director				Age (In yrs. I	ast birthday)	If Under Months		If Under Hours	24 Hrs. Min.	8. Date of B. (Month, D June)	irth lay Year	926	Count	ace (State or Foreign ry) Land
	ne Maryland Be-1 show	Director	MD Balt	imore	10c. City	Esse	x								od. Inside City Limits 1 ☐ Yes 2 ☑ No
	th with the 23a or 2	ai Dire	10e. Street and Number 907 Lutz Av	e.			10f. Zip	221				USA		Vhat Count	ry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or Items 23a or 28e-f show says injury or other treumatic event, I'm Medical Era Lifet must be notified at ODGE.	Completed by Funeral	11. Marital Status  1 Never Married 2 Marrie 3 XWidowed 4 Divorced	12. Was Deceder Armed Force at   Tyes 22 If Yes, Give Year or Dates	s? ⊈No		Was Deced If Yes, spec				ecify Yes or N Rican, etc.)	0-	Blac	e - America k, White, e : Whi	tc.
Maryland 21215-0036	i within 72 ho jiene. r than "netur the Medical	ompleted	15. Decedent: (Specify only highest Elementary/Secondary (0-12) 11th	s Education grade completed) College (1-4c	or 5+)	16a. Dece (Give life. Offi	dent's Usua kind of wor DO NOT us CE W			t of worki	ing	Ch	esta	siness/Ind peck Drag	
yland;	should be filed and Mental Hyg marked othe umatic event,	To Be C	17. Father's Name (First, Middle, L James Vandet	ti					The	lma	First, Middle Leese	2			
	and 2 sh ealth and n 27 Is m		19a. Informant's Name/Relationsh Phyllis Hue				-				al Route Numb Ltimor	•		State, Zip	Code)
Baltimore,	permit. Pages 1 a Department of He Importent: If item eny injury or oth		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation  '4 ☐ Donation 5 ☐ Other (Sp	ecify)	1 c		ill	ther place Ceme	eter	y 11	) ate / 23 / 0			City or Tov	vn, State e MD
Ba	permit Depar Impor eny in		21. Signature of Funeral Service L  23a. Part1. Enter the disease, or shock, or heart failure. Liste	1 onne	dy sed the deatr		2. Name and	) Ma	ice 7	CO	Balt	imo			Approximate
	Physician /Medical		shock, or heart failure. List'd Immediate Cause (Final disease or condition resulting in death)	a		troke									Interval Between Onset and Death
8760,	Examiner be executed by physician and burial-transit sthe burial-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying (1969) Jesus J. Hessel J. Highly that initiated events resulting in death) Last	С	as a consequas a consequ										
.O. Box 68	The law requires that the death certifica tie has been signed by the attending ph page 2 should be delached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 M No 9 ☐ Unknown	23c. If yes, outcon 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2  Fetal at time of de	death 3	Ectopic pro						23d. Dat Mor	e of deliver	y Day Year
<u>a</u>	w requires that t been signed by should be deta	by	Part II. Other significant condition	ns contributing to death	but not rest	ulting in the u	nderlying ca	ause give	en in Part I.			tobacco Yes 2		ibute to the	cause of death?
al Records,	10	Completed										opsy ormed?		Vere autop rior to com leath?	sy findings available inpletion of cause of 2 No
Division of Vital	ding Phy n. After this funeral d	Certification: To Be	25. Was case referred to medical examiner?  1	ation		ER/Outpatier 28b. Time o Injury		Bc. Injury Work	ar: 4 □ Nu	rsing Ho	n <i>(Check only</i> me 5 □ Res 28d. Describe	idence how inj	ury occurr	ed	
Dİ	or fte	Certific	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determine	ned 289. Place of	Injury - At ho etc. (Specify	ome, farm, str	reet, factory	, office			28f. Location City or To			er or Rural	Route Number,
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	one)	g Physician: To the be Examiner: On the basis and manner	st of my kno s of examina stated.	wledge, deat tion and/or in			e, date an pinion, dea number	d place, a	and due to the ed at the time		-	nner as sta and due to I (Month, D	
	Viti To	=	29b. Signature and title of certifier	Mille	MD		290	_	768	3		250. 0	11/21		ay, rear)
	5		30. Name and address of person v	25 Main S	trus .	Sinte	200	Renh	news	jh	a				
	Sta Registi		31. Date filed (Month, Day, Year)	005 ab. Regi	strar's Signa	ture	A STATE OF THE STA								

		1	For State Registrar		Department of Health and I Certificate of Death		2005	37584
	Physicia		1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death 7:45PM
	/Medica	al -	GAIL MARGARET HART  4a. Facility Name (If not institution, give st.	reet and number)	4b. City, Town, or Location of Death	11	4c. County of Deat	4
	EXAMILIE		GOOD SHYARI	TAN HOSPITA	K BACTIMOR		BALTIMORE	
	Funeral Director		210~40~0030	7. Age (In yrs. last bir	thday) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Sept. 16	Year) 9. Bin 6,1941 Mar	hplace (State or Foreign untry) cyland
	land ow	-	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town	n or Location			10d. Inside City Limits
	e Many	ctor	Maryland Baltimore	Ba	altimore County			1 Yes 3 No
	th with the 23s or 28	Funeral Director	10e. Street and Number 8218 Harris Avenue		10f. Zip Code 21234	10	og. Citizen of What Co USA	
036	swithin 72 hours after death with the Maryland jiene. r than "natural", or Items 23s or 28s-f show the Medical Evaluate must be redified at the Medical Evaluate must be redified at	þ	11. Marital Status 1.  1 □ Never Married ※ Married 3 □ Widowed 4 □ Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes X 2 □ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	o Rican, etc.)	14. Race - Ame Black, Whit	e, etc. ite
Maryland 21215-0036	- 50	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	rking E	Baltimore ( Support Gro	Cancer
121	filed within I Hygiene. other than rent, the M		12 yrs.  17. Father's Name (First, Middle, Last)	N/A	Director  18. Mother's Nar	ne (First, Middle, M		
and	og ag b	To Be	James Verner Marti	n	Pauline	Elizabeth	Schafer	
ary	2 should and Men Is marke aumatic		19a. Informant's Name/Relationship (Typ		o. Mailing Address (Street and Number or Ru			
e, N	1 and 1ealth 9m 27 ther tr		Chauncey William Ha		218 Harris Avenue Ba		Mary Land 20c. Location - City or	Z1234 Town, State
Baltimore,	Page nent o ant: If ury or		20a. Method of Disposition  1 Burial Commation 3 Re  4 Donation 5 Other (Specify)	Mecro	crematory or other place) Crematory Inc.   11-		Baltimore,	Md.
Balt	permit. Departr Imports any inju		21. Signature of Funeral Service License	ahn	22. Name and Address of Facility Lassann Funeral H 7401 Belair Rd. Ba	ome ltimore,	Md. 21236	
			shock, or heart failure. List only on	cations that caused the death. Do e cause on each line.	not enter the mode of dying, such as cardia	VIII ON POST STORY		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence	EC BREAST CA	RCITURN	4	
	Examiner	<u>_</u>	Sequentially list conditions, bif any, leading to immediate	. Due to (or as a consequence	of):			
v	uted d ansit	Examine	Cause (Disease or injury					
68760,	icate be executed physician and s the burial-transit	al Exa	resulting in death) Last	Due to (or as a consequence	of):			
	tificate ig phys as the	Redical						1
P.O. Box	The law requires that the death certificate has been signed by the attending to age 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 XNo 9 □ Unknown	3c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	h 3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of de Month	livery Day Year
	uires that the signed by ld be detac	by	Part II. Other significant conditions con	tributing to death but not resulting	in the underlying cause given in Part I.		oacco use contribute t es 2⊠No 3□P	o the cause of death?
of Vital Records,	e law require has been si je 2 should l	Completed				24a. Was a autops perforr	y prior to death?	utopsy findings available completion of cause of
tal		Be Co	25. Was case referred to medical		26. Place of De	ath (Check only on	2 <b>X</b> No 1 Yes	s 2 <b>X</b> No
i Vi	Physicien: r this certific ral director,	To B	examiner? 1 ☐ Yes 2 🔀 No	lospital: 1 Inpatient 2 ER/C			ence 6 Other (Spe	əcify)
o uc	Jing Pl		27. Manner of Death  1   Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year) 28b.	Time of Injury at Work?  M 1 \( \text{Yes} \) Yes 2 \( \text{No} \) No	28d. Describe no	ow injury occurred	
Division	or Attending after death. Director: After in by the fune	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)		28f. Location (St City or Town	treet and Number or R n, State)	lural Route Number,
J	Hospitel 4 hours a Funerel tely filled	Medical Ce	29a. Certifier 1 🗷 Certifying Phys (Check only one) 2 ☐ Medical Exami	sician: To the best of my knowledger: On the basis of examination a and manner stated.	ge, death occurred at the time, date and place and/or investigation, in my opinion, death occ	curred at the time, d	ate and place, and du	e to the cause(s)
)	To the within 2 To the complet	Me	29b. Signature and title of certifier	OUGERGI, MI			11 , 17, 2	2005
	20		30. Name and address of person who co	mpleted cause of death (Item 23a	(Type, Print) MD. GOOD SI	MARIT	AN HOS	PITAC
	St Regist	ate rar	30. Name and address of person who compared to the second	32. Registrar's Signature	Joseph .			

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Donald G. Hicks November 18, 2005 7:40 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1105 Ryegate Road Towson Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year, 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) 1 ■ XM 2 □ F 80 Director 212-20-7020 6, Aug. Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location If item 27 is marked other then "natural", or items 23a or 28a-1 show or other traumatic event, the Modical Examinar must be multipled at 10d. Inside City Limits 1 ☐ Yes 2 🗖 No Directo Maryland | Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or itama 23a any hijury or other traumatic event, the Medical Examiner must anong. 1105 Ryegate Road 21286 Funerai U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🂢 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Specify White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) General Contractor Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Be Robert Η. Hicks Mildred Kummer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hicks Douglas G. Son 19 Florida Road Towson, Maryland 21204 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Druid Ridge Cemetery 11-25-2005 Pikesville Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deat Immediate Cause (Final disease or condition resulting in death) Physician Juoblastoma 1 month /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Tyes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy 1 ☐ Yes After this certification funeral director, p or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death | Check on vone Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home Residence 6 Other (Specify) 1 🗌 Yes 은 2 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 2 ☐ Accident Injury 5 Pending death. investigation 1 ☐ Yes 2 ☐ No filled in by the within 24 hours after deat To the Funeral Director: 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Prifying Physician: To the best of my knowledge, death occurred at the time, date and blace and due to the cause(s) and manner as ablact 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00056919 11/18/2005 30. Name and address of person who cometed cause of death (Item 23a) (Type, Print) 21204 Robert B. Donegán, M.D. 6569 N. Charles Street, Suite 205W Baltimore, Maryland 31. Date filed (Month, Day, Year) 32. Registr 🍻 Signature State NOV 2 2 2005 Registrar

			4 101	partment of Health and Mertificate of Death		2005	37586
			Decedent's Name (First, Middle, Last)		2. Date of Death Month		3. Time of Death
	Physici /Medio		Alice Mae Hosse		11	Day Year 17 05	1:45 P <sup>M</sup>
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Dea	
			2245 Evelyn Drive	Pasadena		Anne	Arunde1
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Y	'ear)   C	thplace (State or Foreign ountry)
	Director		216-10-1581 00		5/1/191	7	MD
	and		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits
	danyl f eho	ō					1 ☐ Yes 2 🗶 No
	the t	Director	MD Anne Arundel  10e. Street and Number	Pasadena 10f. Zip Code	100	. Citizen of What C	ountry?
	with with						
	heath ms 23	Funeral	2245 Evelyn Drive  11. Marital Status 12. Was Decedent Ever in U.S. 13	21122 Was Decedent of Hispanic Origin? (Sp.	ecify Yes or No-	14. Race - Am	USA erican Indian.
·0	r Her o	F	Armed Forces?  1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No	. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, Whi	
ဗ္ဗ	ol', o	by	3 XWidowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 💢 No Specify:		Specify:	hite
P	be filed within 72 hours after death with the Maryland ntal Hygiene.  ed other then "naturel", or items 23s or 28s-f ehow event, the Medical Examinar must be notified at	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Gi	edent's Usual Occupation	16	b. Kind of Business	
21	thin 7	pje	Elementary/Secondary (0-12) College (1-4or 5+)	re kind of work done during most of work DO NOT use retired)	ing		
2	er th	ő	6	Seamstress		State	of Maryland
5	al Hygik d other event, t	Be (	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, Ma	iden Sumame)	
Maryland 21215-0036	should be ind Mental i marked o umatic eve	ပ	John C. Wood	Mary E.	Martin		
a	and and sm		19a. Informant's Name/Relationship (Type, Print) grand- 19b. Ma	ling Address (Street and Number or Run	al Route Number, C	City or Town, State,	Zip Code)
	7 <b>5</b>			122 Whites Cove Ro		idena, MD	21122
altimore,	of Hea of Hea if Item or othe		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	position (Name of ematory or other place)	Date 20	c. Location - City or	Town, State
Ě	Pages ment of ant: If it ury or o			en Mem. Park 11/2	1/2005	Glen Burn	nie. MD
ä	permit. Pages Department of Important: If II any Injury or o		21. Signature of Funeral Service Licensee	00 No. 10 10 10 10 10 10 10 10 10 10 10 10 10			Home, P.A.
<u> </u>	202299		Mark a Vanue MO1357	1 Second Avenu			
			23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arrest	t,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition a. Pneumo	nia			Onset and Death
	/Medical		resulting in death)  Due to (or as a consequence of):	<i>/</i> C(0)			7,0015
	Examiner		Sequentially list conditions, bb.	n'a			years
	ש ב	Examiner	ii arry, leaduring to mimediate cause. Enter Underlying Cause (Disease or injury				years
	acute ind trans	E	that initiated events c.	·			years
Ö,	cate be executed obysician and the burial-transit		Due to (or as a consequence of):			11	₹1
8760	hysic the b	dical	d				
9	0	Med	IF FEMALE:				- 3
Box	eath certif attending for use a	Physician/Me	23b. Was decedent pregnant in the past 12 mosts?	□Ectopic pregnancy		23d. Date of de Month	livery Day Year
o O	at the dea by the a tached fo	Sic	1 ☐ Yes 2 No 4 ☐ Pregnant at time of death 5 9 ☐ Unknown 9 ☐ Unknown	Other (specify)		Month	Day real
<u>.</u>	d by	F	Part II. Other significant conditions contributing to death but not resulting in the		00- Didustra	1	
ŝ	The law requires that the te has been signed by the has been signed by the rage 2 should be detache		Chronic abother the	. 1.		1	the cause of death?
20	w require been sig should b	sted	CHOMIC 0231 OCATVE	ulmonary	1 🗆 Yes	No 3LP	robably 4 Unknown
Record	alaw asb	Completed by	diseace, chronic r	enal o	24a. Was an autopsy	prior to	utopsy findings available completion of cause of
	0 1	S	insufficiency		performe 1 ☐ Yes 🎉		2 □ No
Vital	Attending Physician: r death. sctor: After this certific by the funeral director,	Be	25. Was case referred to medical examiner?	26. Place of Death	(Check only one)		
	Physic this o	P.	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpate			e 6 □Other (Spe	cify)
Ĕ	ding P. After funera	Certification:	27. Manger of Leath 1 Natural 5 □ Pending 28a. Date of Injury (Month, Day Year) 28b. Time Injury	Work?	28d. Describe how	injury occurred	
Division of	ttendi death. ctor: A y the fu	cat	Accident investigation  3 Suicide 6 Could not be	M 1 Yes 2 No			
≥	or At after of Direction by	E	4 Homicide determined 28e. Place of Injury - At home, farm, so building, etc. (Specify)	treet, factory, office	28f. Location (Stree City or Town, S	et and Number or Ri State)	ural Route Number,
_	Hospital		200 Capitian				
	Hos E4 ho Fun tely f	lica	29a. Certifier Check only one) Medical Examiner: On the basis of my knowledge, de and manner stated	ith occurred at the time, date and place, a investigation, in my opinion, death occurr	and due to the caus ed at the time, date	se(s) and manner as and place, and due	s stated. e to the cause(s)
	To the Hospital or Attentwithin 24 hours after deati To the Funeral Director: completely filled in by the	Medical	one) and manner stated.  29b. Signature and title of certifier	29c. License number	704	Date signed (Mont	h Day Year)
1	F 3 F 8		mmy	DYIAT	-	-	
/	/		30 Name and address of person who completed cause Adeath (Item 23a) (Type	- 1179 J		11.18	- U2
1			TVA PARTIE AND ADDIESS OF DEISON WIGGEDINDIENED CAUSE ANDRAIN (ITAM 233) (TVA	s. munu			
1			Poherca FlomMD SCAINE	te vane this but	The M	elloss.	11/2 2108
Y	Sta	te.	Pelsecca Clonm 8601 Vo 31. Date filed (Month, Day, Xear) 105 32. Registrar's Signature	tevans Highw	ayle	illessi	ille UD

State of Maryland / Department of Health and Mental Hygiene 37587 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November T8,2005 **Physician** Vera M. Hanna 1:11 A. M /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Heart Home Assisted Living Lutherville Baltimore County If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
June 04, 1948 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1□M 2 F Months Czechoslovikia 57 Yrs 055-40-1381 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits 7 is marked other than "natural", or itame 23a or 28a-f ehow treumatic event, the Medical Examinat must be motified at 1 TYes 249 No Maryland Baltimore County Lutherville Directo 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21093 1414 Front Ave. United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours efter Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Middle School Teacher Education 06 Pages 1 and 2 should be filed vent of Health and Mental Hygient: If item 27 is marked other? 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Vaclay Raz Vera Borian 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15 Warwick Mill Court Cockeysville Maryland 21030 Mr. Ned Hanna, Jr. (Husband) 20b. Place of Disposition (Name of cometery, crematory or other place)
Evans Funeral Chapel 20c. Location - City or Town, State 20a. Method of Disposition Nov. 19 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ö permit. Page Department o Importent: If any Injury or Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Peaceful Alternatives Funeral&Cremation 2325 York Road Timonium, Maryland 210 21. Signature of Funeral Service Licensee sease, ir implications that mused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part Finter he sea shoot or he it failure Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due to (or as a consequence of): disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): The law requires that the death certificate be executed use as the burial-transit attending physician and that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown been signed by the should be detach Part II. Other significant conditions contributing to death but not regulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 3 NO 3 Probably 4 Unknown 1 ☐ Yes Be Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No hask certificate 1 ☐ Yes 2. NO or Attending Physician: funeral director 25. Was case referred to medical-26. Place of Death (Check only one) assisted examiner' Other: 4 Nursing Home 5 Residence 6 (Specify) Certification: To 1 Tyes 2 N 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manne eath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury atural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident the Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a 29a. Certifier 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) Type, armel 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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	Examin	er	4a. Facility Name (If not institution, give street and nymber)		4b. City, Town, or Location of De	ath	4c. County of Death
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	28a-f	Director	10e. Street and Number	DA	LDMORE 10f. Zip Code	100	Citizen of What Country?
	3a or		2604 Taylor Ave.		21234	log. v	1) SA
	death	Funeral	11. Marital Status 12. Was Decedent Ever in L Armed Forces?	J.S. 13.	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pur	(Specify Yes or No-	14. Race - American Indian,
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21215-0036	within 72 hours after death with the Maryland one. Than "natural", or Itams 23a or 28a-f ahow natural Examirer must be motified at	ed by	3 Widowed 4 □ Divorced Year or Dates:  15. Decedent's Education		dent's Usual Occupation		white
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Baltimore	permit. Pages Department of Important: If i any injury or once.		21. Signatur of Funeral Service Licensee		2. Name and Address of Facility	induce m	
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			23a. Part1. Enter the diseased or complications that caused the dea shock, or heart failure. List only one cause on each line. Immediate Cause (Final	h. Do not ent	er the mode of dying, such as cardi	ac or respiratory arrest,	Approximate Interval Between Onset and Death
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8760,	rcate be executed physician and s the burial-transit		resulting in death) Last Due to (or as a consec	(uence of):			i.
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ŏ	eath certiti attending p	In/M	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fett		Ectopic pregnancy		23d. Date of delivery
Э. В	e death he atte	Physician/Me	1 Yes 2 No 4 Pregnant at time of c		Other (specify)		Month Day Year
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Records,	The law requires that the death certiticate be executed its has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	ted by	Takin. Other significant conditions contributing to deal in but not res	alting at the dr	nderlying cause given in Part I.	1 ☐ Yes	ouse contribute to the cause of death?  2 No 3 Probably 4 Unknown
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						performed? 1 ☐ Yes 2 X	death?
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o	g Phys er this eral di	n: To	27. Manner of Death 28a. Date of Injury	ER/Outpatien 28b. Time of	28c. Injury at	Home 5X Residence 28d. Describe how inj	6 ☐Other (Specify) ury occurred
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	To the Hospital or Attanding Physician: within 24 hours after death To the Funeral Director: After this certific completely tilled in by the funeral director,	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my know (Check only one)  1 Medical Examiner: On the basis of examina and manner stated.	ition and/or inv	occurred at the time, date and place vestigation, in my opinion, death occurred.	ce, and due to the cause( curred at the time, date a	s) and manner as stated. nd place, and due to the cause(s)
	To th Within To th compl	Me	29b. Signature and title of Pertifier		29c. License number	29d. D	ate signed (Month, Day, Year)
			14.4 13 aver Dum	)	0002894	9 1	1/22/05
4			30. Name and address of person who completed cause of death (Iter	n 23a) (Type,			
	C		31. Date filed (Month, Day, Year)  32. Poistrar's Signi	SIIろ。	Hartard KG. St	IN Duni	LORE MD21234.
	Sta Registr	_	NOV 2 2 2005 Assess	B. A	and a		

Amend item#1, permit of Health and Mental Hygiene 0 55 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Charles Edward Hoerichs 2. Date of Death 3. Time of Death **Physician** Charles Edward Hoericks 20. 2005 /Medical November 10:20 P 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1168 River Bay Road Annapolis
| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)
| Months | Days | Hours | Min. (Month, Day, Year) Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□ F Yrs. Director 93 216-05-7689 Dec.29. 1911 Maryland Usual Residence of Decedent 10a State 10c. City, Town or Location 10h County 10d. Inside City Limits 28a-f ahow 27 Is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Exertion must be notified at 1 ☐ Yes 2 ☑ No Maryland Anne Arundel Annapolis Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1168 River Bay Road 21049 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 □ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Armv 1 ☐ Yes 2 ☑ No Specify: þ Specify White 3 N Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) se filed within al Hygiane. Edward Hoerichs & Son College (1-4or 5+) Elementary/Secondary (0-12) Plumbing & Heating Co Office Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ā and Mental 2 Edward Hoerichs Mary E. Uhlenberg 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) itam 27 Carol H. Moore 3483 Olympia Road; Davidsonville, MD 21035 Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any Injury or o 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Woodlawn Cemetery 11/23/05 Woodlawn, Maryland 21. Signature of Funeral Service vicense 22 Name and Address of Facility
Witzke Funeral Home of Catonsville, Inc. 11)10 1630 Edmondson Avenue; Catonsville, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final/ Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): nding physicien and use as the burial-transit certificate be executed Exami that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23h. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy ρ Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. been signed by the s should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Conknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 No this certificate Vital 1 Yes 1 ☐ Yes 2 ☐ No Physicien: : After this certification of funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DDA ō 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: Division 1 Matural 5 Pending investigation To the Hospital or Attending within 24 hours effer death.
To the Funeral Director: Afte completely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 21438 ed cause of death (Item 23a) (Type, Pript) DEFENSE HIGHWAY MICHAEL 31. Date filed (Month, Day, Year) 32 Registrar's Signature State NOV 2 2 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene-1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Joseph Brendan Herron November 18, 2005 6:15 P.M /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 719 Maiden Choice Lane HR#103 Catonsville Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours 1₫M 2□F 213-28-8505 Director 74 Pennsylvania Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "naturel", or items 23a or 28e-f show other traumatic event, the Medical Exercited at the traumatic event, the Medical Exercited at 1 ☐ Yes 2 ☑ No Director Maryland Baltimore Catonsville 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? 719 Maiden Choice Lane HR#103 Funeral 21228 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No Specify: Be Completed by 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Independent Insurance Agent Insurance permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important: If item 27 is marked otherny injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Joseph A. Herron Marie Brennan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daughter 645 Maid Marian Hill, Sherwood Forest, MD 21405 Mary Jean Herron 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) New Cathedral Cemetery 11/22/05 Baltimore, Maryland 21. Signature Superal Survice Licensee 22.Name and Address of Facility Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 Fart1. En it he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, heart failure. List only one cause on each line. Approximate Interval Betw shock, eart failu Immediate cause (Final disease or condition resulting in death) **Physician** Sta /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed use as the burial-transit Schoodson and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, been signed by the attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy ō in the past 12 months? Dav 5 Other (specify) 1 Yes 2 No should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No has page 2 autopsy performed? certificate 1 Yes 2 10 No Attending Physicien: 25. Was case referred to medical examiner? filled in by the funeral director, Certification: To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide ö within 24 hours a To the Funerel D Hospital 1 Crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier completely 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 Deneen 04437 21228 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Deneen Bowl 31. Date filed (Month, Day) Year) Maiden 711 32. Registrar's Signature State Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Nonth VOV **Physician** 2005 1:29 8 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Bah More cours N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months, Day, Year) Aug. 31, 1 .7. Age (In yrs. last birthday) 6 Sex 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** 69 Months 1 M 2 TH Yrs 1936 Maryland Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State r than "natural", or itams 23s or 28s-f show the Medical Examiner must be notified at 1 XYes 2 No **Funeral Director** MD N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21230 1138 Carroll Street United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊡ Yes 22 No If Yes, Give Year or Dates: 14 Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married White 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify. Be Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker traumatic avant, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be 1 Department of Health and Mental I Important: If item 27 Is markad o any injury or othar traumatic ava William Henry Grieves Helen Elizabeth Ashby 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John S. Blum Son 100 West 5th Avenue, Baltimore, MD 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) Western Cemetery 11-21-2005 Baltimore, MD 21. Sig atu e of Funeral Service Licens 22. Name and Address of FacilityAmbrose Funeral Home of Lansdowne 2719 Hammonds Ferry Rd., Lansdowne, MD21227 29a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PREUMONIA **Physician** /Wedical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760. attending physicien for use as the buria Physiclan/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death in the past 12 months? Year Month Day 4□Pregnant at time of death 5 Other (specify) the 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à pe 1 Yes 2 No 3 Probably 4 Uriknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? (es 2 No has page certificate 1 Yes Division of Vital To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 Impatient 2 ER/Outpatient 1 Tyes 2 → No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 3 DOA this 28a. Date of Injury (Month, Day Year) After thi 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Injury 1 Natural 5 Pending 1 Tyes 2 No death. investigation 2 Accident filled in by the Diractor: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide after within 24 hours a
To the Funaral C I 🖵 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier NOV 17, 2005 erson who completed cause of death (Item 23a) (Type, Print) 10 2000 La Mari 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			1 - For State Registrar	State of Man	yland / Dep <i>Ce</i>	artme ertifica	ent of H	lealth ai Death	nd Me	ental Hy	/gie Reg.	a U U	5	37592
	Physici /Medic		1. Decedent's Name (First, Middle, Last	Snyder Har	r				-	2. Date of D Month lovemb		Day 20, 2	Υθαr 2005	3. Time of Death 7:31 PM
	Examin		4a. Facility Name (If not institution, give Holy Cross Hospit					Location of Sprin				4c. County Mont	of Death	У
7	Funeral Director	e:	1/6-16-030/	x 7. Age (/ M 2□F 8	n yrs. last birthday 5 Yrs.	Month	der 1 Year s Days	If Under 24 Hours	Min	Date of Bi (Month, D ept.	au Ve	1920	Cour	place (State or Foreign htty) Sylvania
	Aaryland Febow	ō	Usual Residence of Decedent           10a. State         10b. County           Maryland         Montgome		Dc. City, Town or L		Sprin	20					1	0d. Inside City Limits 1 ☐ Yes 2 ⊠ No
	with the had or 28a-	Direct	10e. Street and Number		51		Zip Code					Citizen of		
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Madical Examinar mata be notified at	by Funeral Director	12109 Selfridge F  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 ☑ Yes 2 ☐ No	or in U.S. 13.	If Yes, s	209 cedent of Hi cecify Cuba 2\square No	306 ispanic Origin, Mexican, Specify:	in? (Specit Puerto Ric	fy Yes or N can, etc.)			ce - Americ ck, White,	an Indian, etc.
21215-0036	within 72 ho ene. than "natur the Medical i	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		(Give	9 kind of DO NOT	sual Occupa work done of use retired	during most o	of working	Ī		o. Kind of B		,
Maryland 2	uld be filed Aental Hygi rked other tic event, I	To Be Co	17. Father's Name (First, Middle, Last) Unknown		nqui	Jill Cill	. opei	18. Mother's		First, Middle	, Maio		-	115
	ind 2 shore aith and M 27 is ma er trauma		19a. Informant's Name/Relationship (7) Thomas E. Harr/Son		1.			and Number						· ·
altimore,	Pages 1 and of Heren of Heren of Heren of Heren or other or other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	Place of Disp cemetery, cre Parklawn Par	osition (A matory o Memo	lame of r other place	<sub>e)</sub>	Date 0v. 2 2005	3.	20c	. Location -	City or To	
Balt	permit. Departn Importa any injk		21. Signature of Funeral Service Licens	1	Ro	2 Name bert	A. P	s of Facility	ey Fu	neral	Нс	me/Ro	ckvil	lle, Inc. 20850-2805
8760,	Physician //Medical Examiner subspicion and subspic	dical Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, is admit to mine allaticause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		yocardial onsequence of):				ardiac or r	espiratory a	irrest,			Approximate Interval Between Onset and Death
P.O. Box 6	death certiff e attending ad for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3	⊒Ectopic ⊒ Other (	pregnancy specify)					23d. Dai Mo	te of delive	ny Day Y <i>e</i> ar
	law requires that the de as been signed by the a 2 should be detached f	by	Part II. Other significent conditions cor	ntributing to death but n	ot resulting in the u	ınderiying	cause give	n in Part I.		_				e cause of death? ably 4 ⊠Unknown
Division of Vital Records,	The tate h	Completed								24a. Was auto perfo 1 □ Yes		? 5	Were autoportor to condeath?	osy findings available appletion of cause of 2 \( \text{No} \)
¥	Physician: r this certifica ral director,	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☒ No	lospital:	25 CD/O		Othe	26. Place o						
ion of	ing Phy After this uneral d	atlon: To	27. Manner of Death  1 🖾 Natural 5 Dending 2 Accident investigation	1 ☐ Inpatient  28a. Date of Injury (Month, Day Ye	2 ⊠ ER/Outpatie 28b. Time o Injury		28c. Injury Work	at	280	5 ☐ Resi	-			')
Divis	2 th 2 c	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (5	Specify)					City or To	wn, St	ate)		Route Number,
	To the Hospital of within 24 hours at To the Funeral D completely filled in	Medical	29a. Certifier 12 Certifying Physics (Check only one) 2 Medical Exami	sician: To the best of m ner: On the basis of exa and manner stated	y knowledge, dea amination and/or in	th occurre ivestigation	d at the tim on, in my op	e, date and p inion, death	place, and occurred	d due to the at the time,	cause date a	e(s) and ma and place, a	nner as sta and due to	ated. the cause(s)
)	To th within To th compl	Me	29b. Signature and title of ceptifier	Jether	ns	2	9c. Licens <i>e</i>	number 32417				Date signed		Day, Year) , 2005
	1071		30. Name and address of person who of Rahul Giwtra, M.D.		orgia Av		Whe	aton.	Marvi	land 2	າດດາ	02		
	Sta Registr		31. Date filed (Month, Day, Year) NOV 2 2 200		Signature		,		y -	Land 2	.07			

State of Maryland / Department of Health and Mental Hygierie () 5 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Porten be 16 30 **Physician** Zecs /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE AUGSBURG HOME BALTIMORE COUNTY If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Feb. 4, 1920 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□M 2√□F Yrs 85 125-03-9038 Director Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or Items 23a or 28e-4 show any injury or other treumatic event. If a Nedical Exercit actionst be notified at 1 ☐ Yes 2√No ⊉Maryland Baltimore County Baltimore Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21207 USA 6811 Campfield Rd. by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status □Yes 2√ No 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: If Yes, Give Year or Dates: x3√ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) N/A 12 yrs. Homemaker Homemaking~Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Harry Holtz Viola Krebs ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8009 Wynbrook Rd. Baltimore, Md. 21224 Louis M. Matthai (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State XIX Burial 2 ☐ Cremation 3 ☐ Removal from State 11~19~05 Baltimore, Maryland Baltimore Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee <sup>22</sup> Name and Address of Facility Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236 Lassahn 6 Approximate Interval Between Onset and Death 23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Priysician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, many leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed the attending physician and ched for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No should be detached 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Division of Vital Records, 2 910 3 Probably 4 □Unknown 1 ☐ Yes Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 2 □ No 1 ☐ Yes 2 4 1 ☐ Yes Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 1 Tes Certification: To 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Director: After Hospitel or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funerel L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the 29d. Date signed (Month, Day, Year) 29b. Signatur 29c. License numbe and address of person who completed cause of death (Item 23a) (Type, Print) BOBMO

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

2005

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32. Registrar's Signature

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	Physici	an	Registrar  1. Decedent's Name (First, Middle, Last)	Tolli		incan	- 01 L	eatri	2	Date of Dea	th Day	Year	3. Time of Death
96.5% 0.00	/Medic Examin	al	4a. Facility Name (If not institution, give si	treet and number)	5 <u>0</u>	4b. City,	Town, or t	ocation o	f Death	<	4c. County	of Death	9:48
	Funeral		5. Social Security Number 6. Sex	v 7. Age (In yrs. I	ast birthday)	If Under		If Under 2		. Date of Birth	ISAL	9. Birthp	OICO
	Director		218-22-5326	M 20 F 76	Yrs.	Months	Days	Hours	Min.	(Month, Day 05/25,	1929	MAR	YLAND
	show	2	10a. State 10b. County  MD N/A		, Town or Lo		. O.T.	п37				1	0d. Inside City Limits 1 XYes 2 No
	r 28a-f	recto	10e. Street and Number		BALTI	10f. Zip		L Y		1	10g. Citizen of \	What Cour	
	23s o	alD	3409 MILFORD A	VENUE			2120	7			US	A	
036	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If Item 27 is marked other than "natural", or Iteme 23a or 28a-f show or other traumatic event, the Medical Examinal must be redified at	by Funeral Director	11. Marital Status 1 1 Never Married 2 Married 3 Nover Married 4 Divorced	2. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Dates:		Was Deced f Yes, spec I Pes		panic Orig , Mexican, Specify:	gin? (Specr , Puerto Ri	fy Yes or No- can, etc.)	14. Rac Blac Specifi	e - Americ ck, White, : BL	
5-0036	"natural",	eted	15. Decedent's Educ (Specify only highest grade		16a. Deced	kind of wo	rk done du		of working		16b. Kind of B	usiness/In	dustry
2121	giene. er then "	Completed	Elementary/Secondary (0-12) 1 2 T H	College (1-4or 5+)		EAMS		SS		The state of the s	DRAPE	RYIN	DUSTRY
Maryland	uld ba filed Aental Hygir rked other tic event, ti	To Be (	17. Father's Name (First, Middle, Last)  JAMES KELLY							First, Middle, . HARRIN	Maiden Suman IGTON	1e)	
Mary	ith and Men th and Men 27 is marke traumatic		19a. Informant's Name/Relationship (Typ			•	•				r, City or Town,	9000	100
	ss 1 and of Health Item 27	ļ	JACQUELINE JON	20b. P	lace of Disco.	6 CO sition (Nam natory or o	ne of	1	RD, E		ORE 20c. Location -		
Baltimore,	permit. Pages 1 Department of H Important: If Ite any injury or ott		1  Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	GA	RRISO				11/30				LLS, MD
Ba	Dep Impo		21. Signature Trieral Service Licens	N/X our		. Name an			HEIC				ME 21207 MORE, MD
			23a. Party. Enter the disease, or complic sharty or heart failure. List only on Immediate cause (Final	cations that caused the eath e cause on each line.	Do not ente	er the mod	e of dying	, such as	cardiac or r	espiratory arr	est,		Approximate Interval Between Onset and Death
7	Physician /Medical Examiner		disease of condition resulting in death)	Due to (or as a consequ	uence of):			-				9	4 (1845
(A)	100	Jer	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequ	uence of):	ars	1105	arce	MMA	5/11	a OUX	7	yeur
0,0	ate ba exacuted physician and the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c. resulting in death) Last	Due to (or as a consequ	uence of):							-	
68760,	U 44	edlcal	<b>€</b> d.									-	
Вох	death cer e attendir id for use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	Ectopic pr Other <i>(sp</i>						te of delive	ery Day Year
rds, P.O.	S C 0	þ	Part II. Other significant conditions conf	tributing to death but not resu	ulting in the ur	nderlying c	ause giver	n in Part I.			bacco use cont es 2 □ No		ne cause of death?
Records,	The law require ite has been si bage 2 should b	Completed								24a. Was a autops perform	sy med?	prior to condeath?	psy findings available mpletion of cause of
Vital	ysician: The is certificate had director, page	Be	25. Was case referred to medical examiner?						of Death (	Check only or	•		
4		To It	1 Yes 2 No	28a. Date of Injury	ER/Outpatien 28b. Time of		8c. Injury Work	4 🗀 1401			ence 6 □Oth		y)
Division	Attending r death.	catlor	1 Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	(Month, Day Year)	Injury	М	1 🗆 Y	es 2 □ h					
Δ <u>i</u>	To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After it completely filled in by the funeral	Certification:	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, str	eet, factory	, affice		28	f. Location (S City or Tow		er or Rura	al Route Number,
	• Hospi 24 hou • Funer letely fill	edical	29a. Certifier Certifying Phys (Check only one)  2 Medical Examin	ician: To the best of my kno- ner: On the basis of examinal and manner stated.	wledge, death tion and/or inv	occurred vestigation	at the time , in my opi	e, date and nion, deat	d place, and th occurred	d due to the c at the time, d	ause(s) and ma late and place,	inner as s and due to	tated. the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier				. License				9d. Date signe		
	1		1 fl zon	~ m	22a\ /T =	Reint\	150	36			Doven	her	20, 200
_	Q/		30. Name and address of person who con Talina T Bonaco	ne 302 57	(1ype,	ennt)	06	Be	17	twer	15, N	2(1)	20,000
8	Sta Regist		31. Date filed (Month, Day, Year) NOV 2 2 200	32 Registrar's Signa	ture	31.50							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend items 5, 20b.c per fh 9849 11-22-05 vt

State of Maryland Department of Figure 1 129 15 in the state of Maryland Department of Figure 1 129 15 in the state of Death

For Amend Items 20b820c per FH G849 11-29 15 in the state of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year VIN Vovember 16,2005 /Medical Facility Name (If not institution, give street and number) **Examiner** 4c. County of Death 8. Date of 6. Sex 1 M 2 □ F **Funeral**  Birthplace (State or Foreign Country) Months Days Hours Min. Yrs Director ANL Usual Residence of Decedent the Maryland 10a, State 10b County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 28s or 28s-f show other traumatic event, it is Mudical Examinar must be multiped at Director 1 Yes 2 No MARYLAND 10e. Street and Number 10g. Citizen of What Country? 1000 MOR 2/2 STREE Be Completed by Funeral Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 2 should be filed with and Mental Hygiene. 6 THGRADE NSTRUCTION ONSTRUCTION WOR and 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Pages 1 and 2 Department of Health Important: If item 27 Date CHIKAGO 20 BALTO, MU Baltimore, 20a. Method of Disposition (UN KNOWN) 20c. Location - City or Town, State (State of BALTIMORE), MD 20b. Place of Disposition (Name of & 5 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State TR'INVIY" CEMETERY 11-25-05 any injury o 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Name and Address of Facility BROW JR, FUNERAL HOME nich TON 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last nding physicien and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medicai use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery been signed by the atter should be detached for u 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) Month 4☐ Pregnant at time of death Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Certification: To Be Completed by 23e. Did tobacco use contribute to the cause of death? 4 Unknown 1 ☐ Yes 2 🗆 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate 2 No 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 DInpatient 2 ER/Outpatient this 3 DOA funeral 27. Manner of Death 28c. Injury al Work? 28a. Date of Injury (Month, Day Year) 28b. Time of within 24 hours after death.

To the Funeral Director: After completely filled in by the funer. 28d. Describe how injury occurred 5 Pending investigation Injury м 1 TYes 2 TNo 2 Accident 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide o the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and itle of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2.0 completed cause of death (Item 23a) (Type, Print) n 31. Date filed (Month, Day, Year) NOV 22 rar's Signature State 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 1250 FM Jones November 4 2005 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Hopkins 6. Sex Hi Hospital Ohns Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Pay, Year) **Funeral** Days Months Hours Min 1 □ M 2 C F Yrs. 213-80-6839 32 Sep'18, 1973 MARYLAND Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show d other than "naturel", or Items 23a or 28a-f show event, the Medical Examiner must be nutified at 1 XYes 2 ☐ No Director MD **BALTIMORE** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1414 BOND STREET 21213 U.S.A 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc permit. Pages 1 and 2 should be filed within 72 hours after o Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel; or tien any injury or other treumatic event, the Modical Extendi 1 ☐ Yes 2 👿 No If Yes, Give Year or Dates: 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify. Black Ď 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DOMESTIC HOMEMAKER DOMESTIC 10 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) JAMES MURPHY DONNA KNOX ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2615 E. FAYETTE STREET BALTIMORE, MARYLAND AMIE GOODE SISTER 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place) 1 🔼 Burial € □ Cremation 3 Removal from State 11/19/05 MARYLAND 4 Dogation 5 □ Other (Specify) MT CARMEL CEMETERY 21. Signary of Funeral Service 22. Name and Address of Facility censee Miller"s Metropolitan Chapel P.C. 1639 North Broadway Baltimore, Maryland 21213 . Enter the disease, or complications that caused in for healt failure. List only one cause on each line. Approximate complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Part1 Interval Between Onset and Death mmediate Cause (Final disease or condition resulting in death) Physician nemorrage 1 day Intraperitorieal /Medical Due to (or as a consequence of) **Examiner** Sequenticly list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires thet the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 W Unknown signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown immunodeticiency certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 Yes 2 □ No 1 Tyes To the Hospitel or Attending Physicien: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 9 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3□ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this After thi Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural death. М 1 ☐ Yes 2 ☐ No 2 Accident Director: / 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours at To the Funerel D completely filled it 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai (Check only and manner stated

DHMH 17 Rev 1/2001

State Registrar

NOV 2 2 2005

TEDEURO MI.O.

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

RYAN

600 NORTH WOLFE STREET, BALTIMORE, MARYLAND 32. Registrar's Signature

RESIDENT

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

NOVEMBER 9, 2005

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year Physician Betty Jean Jording NOVEMBER 19, 2005 11:38+ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Saint Joseph Medical Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year)
May 24, 1949 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 💢 F 56 214-54-6697 Maryland Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or Items 23a or 28a-1 show other traumatic event, the Modical Examinar must be notified at 1 Yes 2 No Directo Maryland Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 3019 Linwood Avenue U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 9th Grade 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any jury or other traumatic event poice. 18. Mother's Name (First, Middle, Maiden Sumame) Be Raumond Branham Helen Morris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Jording (husband) 3019 Linwood Avenue, Baltimore, MD 21234 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 11/23/05 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Homes 9705 Belair Rd., Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** RIGHT PLEURAL EFFUSION RECURRENT MONTHS /Medical Due to (or as a consequence of): Examiner TYPE 2 DIABETIC NEPHROPATHY YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physician: The law requires thet the death certificate be executed the burial-transit WITH NEPHROTIC SYNDROME and Due to (or as a consequence of): physicien Box 68760 Be Completed by Physician/Medical for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, OBSTRUCTIVE SLEEP APNEA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ★Unknown 24b. Were autopsy findings available prior to completion of cause of death? STAGE IV SACRAL DECUBITUS ULCER 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2X No 25. Was case referred to medical 26. Place of Death | Check only one examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No Medical Certification; To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu М 1 □ Yes 2 □ No investigation 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Hospital 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 25886 30. Name and address of person who complet of cause of deam (Item 23a) (Type, Print) M. D., ILIA CEBALLOS. OSLER DRIVE. TOWSON, MARYLAND 21204 32 Aegistrar's Signature 7601 31. Date filed (Month, Day, Year) 2005 Registrar

			For State Registrar	State of Mary		artment of H rtificate of I			iene 005	37598
	Physici	20	1. Decedent's Name (First, Middle, La	st)				2. Date of Deat Month	h D <i>a</i> y Ye	3. Time of Death
	/Medic		Mary Celinda	Jackson				11	17 200	
	Examin	er	4a. Facility Name (If not institution, giv			4b. City, Town, or	Location of Death		4c. County of D	eath
	Funeral Director		813 S. Camp Mea 5. Social Security Number 216-34-2271	Sex 7. Age (In	yrs. last birthday) 66 Yrs.	Lit If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 2/2/19	Year) 9.	ne Arunde1 Birthplace (State or Foreign Country) MD
	p ,		Usual Residence of Decedent  10a. State 10b. County	10	c. City, Town or Lo	antion				10d. Inside City Limits
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	ne 23	Funeral	813 S. Camp Mea	12. Was Decedent Ever	in U.S. 13. 1	2109 Was Decedent of H f Yes, specify Cuba		ecify Yes or No-	14. Race - A	USA American Indian,
036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural; or iteme 23a or 28e-f show aumatic event, the Madical Examinar must be notified at	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ⚠ Divorced	Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		f Yes, specify Cuba 1 ☐ Yes 2 <b>XX</b> No	Specify:	Rican, etc.)	Black, V Specify:	White, etc. White
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و	Pages nent of ant: if it ury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	Tuaitina ai iiniii Stata		natory or other plac e Cremati	1			
Baltimore,	permit. Page Depertment of importent: if any injury or once.		21. Signature of Funeral Service Lice	nsee	22	. Name and Addres	ss of Facility	Singlet	on Funera	sville, MD
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5	1		30. Name and address of person who Found M. Ab)	completed cause of death	(Item 23a) (Type, 5. /feno/6	Print) Pr Steel	+ Bulti	more,	MD ZI	205
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			For	State of Marylar	· ·	Health and Mental H	ygiene	37599
			- State Registrar		Certificate of	Death	Reg. No. UU	3/399
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}	Examir		4a. Facility Name (If not institution, give	street and number)	4b. City, Town,	or Location of Death	4c. County of Dea	th
			MARINER HEAL	TH OF GLEN B	BURNIE GLEN	BURNIE	ANNE	ARUNDEL
	Funeral		Social Security Number     6. Security Number	7. Age (In yrs.			lirth 9. Bir Dav. Year) Co	hplace (State or Foreign ountry)
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	er de	aun	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	ff Yes, specify Cul	Hispanic Origin? (Specify Yes or N ban, Mexican, Puerto Rican, etc.)	Io- 14. Race - Ame Black, White	
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ē,	is 1 and is 1 Health item 27 other tr		20a. Method of Disposition	20b. I	Place of Disposition (Name of cemetery, crematory or other pl	Date	20c. Location - City or	
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ă	death a for	cla	in the past 12 months?	1 Live birth 2 Feta 4 Pregnant at time of c		cy	Month	Day Year
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_	6		30 Name and address of person who	completed cause of death (Ite	im 23a) (Type, Print)		7-11-00	-
	7		CARLOS N. PATE	TUNGAME !	92MD 3721 8	TEEST BALTI	mine, MD	21225
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Physician	4		Mental Hygie	C U U O	3/500
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Director		15-66-1563 1 M 2XF 49 Yrs. Months Days Hours Min.    Sual Residence of Decedent   10b. County   10c. City, Town or Location	4-19-	56 M	ary/air
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after death with the Mar referred 23e or 28a-fel referred 12e notified Funeral Director	1	1. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (S. If Yes, specify Cuban, Mexican, Puerl		LSA 14. Race - Ame	erican Indian,
urel; or ite		1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Yes 2 No Specify:		Specify:	lack
is 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hygiene. Item 27 is marken of the then "neture!, or Items 23e or 28e-f show other traumatic event, the Medical Exeminar mant be notified at TO Be Completed by Funeral Director	-	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0·12)  Collect (1·4or 5+)  Collect (1·4or 5+)  Nurse	rking 16th	. Kind of Business teath	are
ould be file Mental Hyg arked othe atic event,	1	7. Father's Name (First, Middle, Last)  18. Mother's Nam  18. Mother's Nam  Edna	ne (First, Middle, Maid	den Sumame)	
1 and 2 sh Health and em 27 le m ther traum		19a. Informant's Name/Relationship ( <i>Type</i> , <i>Primary</i> ) 19b. Mailing Address ( <i>Street and Number or Rumant's Name</i> ) 19b. Mailing Address ( <i>Street and Number or Rumant's Name</i> ) 19b. Place of Disposition ( <i>Name of Number or Rumant's Name</i> ) 19b. Place of Disposition ( <i>Name of Number or Rumant's Name</i> ) 19b. Mailing Address ( <i>Street and Number or Rumant's Name</i> ) 19b. Mailing Address ( <i>Street and Number or Rumant's Name</i> ) 19b. Mailing Address ( <i>Street and Number or Rumant's Name</i> ) 19b. Mailing Address ( <i>Street and Number or Rumant's Name</i> ) 19b. Mailing Address ( <i>Street and Number or Rumant's Name</i> ) 19b. Mailing Address ( <i>Street and Number or Rumant's Name</i> ) 19b. Mailing Address ( <i>Street and Number or Rumant's Name</i> ) 19b. Mailing Address ( <i>Street and Number or Rumant's Name</i> ) 19b. Mailing Address ( <i>Street and Number or Rumant's Name</i> ) 19b. Mailing Address ( <i>Street and Number or Rumant's Name</i> ) 19b. Mailing Address ( <i>Street and Number or Rumant's Name</i> ) 19b. Mailing Address ( <i>Street and Number or Rumant's Name</i> ) 19b. Mailing Address ( <i>Street and Number or Rumant's Name</i> ) 19b. Mailing Address ( <i>Street and Number or Rumant's Name</i> ) 19b. Mailing Address ( <i>Street and Number or Rumant's Name</i> ) 19b. Mailing Address ( <i>Street and Number or Rumant's Name</i> ) 19b. Mailing Address ( <i>Street and Number or Rumant's Name</i> ) 19b. Mailing Address ( <i>Street and Number or Rumant's Name</i> ) 19b. Mailing Address ( <i>Street and Number or Rumant's Name</i> ) 19b. Mailing Address ( <i>Street and Number or Rumant's Name</i> ) 19b. Mailing Address ( <i>Street and Number or Rumant's Name</i> ) 19b. Mailing Address ( <i>Street and Number or Rumant's Name</i> ) 19b. Mailing Address ( <i>Street and Number or Rumant's Name</i> ) 19b. Mailing Address ( <i>Street and Number or Rumant's Name</i> ) 19b. Mailing Address ( <i>Street and Number or Rumant's Name</i> ) 19b. Mailing Address ( <i>Street and Number or Rumant's Name</i> ) 19b. Mailing Address ( <i>Street and Number or Rumant's Name</i> ) 19b. Mailing Address ( <i>Street and Number or Rumant's Name</i> ) 19b. Mailing Address ( <i>Street and Number or Rumant's Name</i> ) 19b. Ma	Date	Ballon State,	Zip Code)  VD 2121
Page ment c ant: If ury or		1 GBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	1/25 B	Henor	e,MD
permit. Departr Importr eny Inj		23a. Part! Enter the disease, or complications that caused the death. Do not enter the mode of pying, such as cardiac	Balo M	d 21212	Approximate
Pnysician /Medical	1	shock, or heart failure. List only one cause on each line.  mmediate Cause (Final disease or condition esulting in death)  a.   Due to (or as a consequence of):	or respiratory arrest,		Interval Between Onset and Death
executed in and inal-transit Examiner	if o C	Sequentially list conditions, and the latest ause. Enter Underlying ause. (Disease or injury hait initiated events c.)			
cate be executed physician and the burial-transit		Due to (or as a consequence of):  d.			
requires that the death certificate be executed seen signed by the attending physician and hould be detached for use as the burial-transited by Physician/Medical Exami	11 2	FFEMALE:  33b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy  1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy  4 □ Pregnant at time of death 5 □ Other (specify)		23d. Date of del Month	ivery Day Year
quires that in signed by uld be deta ed by Ph		art II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacc	N. Ban	the cause of death?
The law ete has be page 2 s	-		24a. Was an autopsy performed 1 Yes 2	prior to death?	topsy findings available completion of cause of
Physician: this certific ral director, TO Be C		Hospital:	th (Check only one) ome 5 Residence	6 □Other (Spec	city)
D 5 6 2		7. Manner of Death 1. Natural 5 Pending 2 Accident Investigation 2 Date of Injury 28b. Time of Injury 28b. Time of Injury 4 Work? 1 Yes 2 No	28d. Describe how in		
pital or Attendir urs after death. sral Director: Af illed in by the fu		4 Homicide determined determined 288. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or Town, St	ŕ	
To the Hospital within 24 hours a To the Funeral I completely filled Medical Ce	2	19a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, one of the basis of examination and/or investigation, in my opinion, death occur and manner stated.	, and due to the cause rred at the time, date a	(s) and manner as and place, and due	stated. to the cause(s)
within To the comp	2	9b. Signature and title gloodifier  29c. License number		Date signed (Monti	n, Day, Year)
10	3	0. Name and ageress of person who completed cause of death (Item 23a) (Type, Print)	CISTH	11 / /6 /	15
		22 South Greene Street Balting MD  1. Date filed (Month, Day, Year) 32. Registrar's Dignature			

			1 - For Stete Registrar	State of M	aryland / Dep <i>Ce</i>	artment of <i>rtificate of</i>		,,	iene		
ı	Physici /Medic		1. Decedent's Name (First, Middle, L	asi) Jacks	OV.			2. Date of Death Month	Day	2005	3. Time of Death
L.	Examir		A mil b Con	etion Extend	hed Cave	BALTI			4c. County		
	Funeral Director		5. Social Security Number 6.  219-07-5358  Usual Residence of Decedent	Sex 1 <del>M</del> M 2 □ F	ge (In yrs. last birthday) 85 Yrs.	Months Days		(Month, Day,	<sup>Year)</sup> 920	9. Birthpli Count MARY	
	Maryland a-f show	tor	10a. State 10b. County  MD CARRO	L	10c. City, Town or Le	ocation FMINSTE	R			10	d. Inside City Limits
	ath with the	rai Director	10e. Street and Number  225 FROCK DR.	APT. 13	5	10f. Zip Code 2115	57		0g. Citizen of 1	What Count	ry?
36	72 hours after death with the Maryland neturel', or Items 23a or 28a-f show Jical Examinations Lean differd at	by Funerai	11. Marital Status  1 □ Never Married 2√2 Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces  1 X Yes 2 If Yes, Give Year or Dates:	No	Was Decedent of If Yes, specify Cui 1 ☐ Yes 2 ☑ No	ban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	Bla	ce - America ck, White, e	tc.
21215-0036	within 72 hou ene. than "neture he Madical E	Completed	15. Decedent's to (Specify only highest g Elementary/Secondary (0-12)	ducation	16a. Dece	DO NOT use retir	ed) during most of wo	orking	16b. Kind of B	usiness/Ind	
	ould be filed within Mental Hygiene. arked other than atic event, ILE Man	Be	12 17. Father's Name (First, Middle, Las		CKSON	MILLWR		me (First, Middle, M	STEEL Maiden Suman RENFEI	ne)	
Mar	nd 2 sh lith and 27 is m r treum	Ţ	19a. Informant's Name/Relationship NAOMI M. JACK	(Type, Print)	19b. Maili IFE 225 1	FROCK D	at and Number or F	lural Route Number, 135, WEST	City or Town,	State, Zip	
Baltimore,	t. Page rtment o rtent: If rjury or		20a. Method of Disposition  Burial 2 Cremation 3  Donation 3 Other (Soc.  21. Sunatur Fin 22 ryice Lice	(עיו	ALL COUNT	matory`or other pla 'Y CREMA	ATION 11	/22/05 LETCHER		VILLE	MD.
Ba	Depa Impo any Ir		23a. Part I. Enter the disease, or co	nolications that cause	d the death. Do not en	54 E. M	MAIN ST.	, WESTM	INSTE	R, MD	
Ĩ	Physician /Medical Examiner		shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death)	a. Advo	ine.	ement					Interval Between Onset and Death
68760,	ficate be executed physician and is the burial-transit	al Examiner	Sequentially list conditions, and the sequential sequence of the sequence of t	c	a consequence of):						
	death certificate e attending phy id for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	4☐Pregnant a	2 Fetal death 3	□Ectopic pregnand □ Other (specify)	су			te of deliver	y Day Year
ds, P.O.	The law requires that the death certif tte has been signed by the attending rage 2 should be detached for use a	by	9 ☐ Unknown  Part II. Other significant conditions	9☐ Unknown	out not resulting in the u	nderlying cause g	iven in Part I.		acco use cont	ribute to the	cause of death?
Records,	The law requires tate has been si page 2 should I	Completed						24a. Was an autopsy perform	24b.	Were autops prior to com death?	sy findings available pletion of cause of
		To Be C	25. Was case referred to medical examiner?  1 □ Yes 2 □ No	Hospital:	ent 2 ER/Outpatier	nt 3 DOA	hon	ath (Check only one	)		I No
Division of	Attending Pher death. rector: After this by the funeral	Certification:	27. Mann of Death  1 Levatural 5 Pending 2 Accident investigate 3 Suicide 6 Could not	20		M 1	uryat ork? ]Yes 2∐No	28d. Describe how	w injury occurr	red	
Σ	000		4 Homicide determine	building, e	jury - At home, farm, str tc. (Specify) of my knowledge, deat			28f. Location (Str. City or Town,	State)		
	To the Hospitel or within 24 hours after To the Funerel Discompletely filled in	Medicai	one) 2 Medical Exe	and manner st	ated.	vestigation, in my	opinion, death occ	urred at the time, da	te and place,	and due to t	he cause(s)
1	121		Heave C  30. Name and address of person who George E. Wic	pompleted cause of	death (Item 23a) (Type,	Print)	11565 R1.1	No D	venb.	er 2	1, 2005
	Sta	ite*	31. Date filed (Month, Day, Year)	32. Regist	3900 Lo	Ch KOVE	en Dout	evava, B	actions	ve, 1	D, 216(0

			For State Registrar	State of Maryla		rtment of l			giene Reg. 200	5 37602
	Physici		1. Decedent's Name (First, Middle, La	ist)	jone	S		2. Date of Dea	Day,	Year 0255 M
	/Medio Examin	er	4a. Facility Name (If not institution, given by FST co	Hospital Ce	nter	Rando		n	.000	rmore
	Funeral Director			Sex 7. Age (In yrs	. (ast birthday) Yrs.	If Under 1 Year Months Days			v, Year) .	9. Birthplace (State or Foreign Country)
	death with the Maryland me 23a or 28e-f ehow crount by pullified at	tor	10a. State 10b. County		A TIM					10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	th the	Funeral Director	10e. Street and Number		ALL THE PART	10f. Zip Code			10g. Citizen of W	
	ath wi	ral		O AVE.		216			U.S.	
	or iteme	nue	11. Marital Status  1 ☐ Never Married 2 ☑ Marned	12. Was Decedent Ever in Armed Forces?  1 ☐ Yes 2 ☑ No	U.S. 13. W	Vas Decedent of I Yes, specify Cub	Hispanic Origin? (S ban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race Black	- American Indian, , White, etc.
5-0036		by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1	☐ Yes 2 No	Specify:		Specify:	Black
2-0	"natural".	eted	15. Decedent's E (Specify only highest gr	ducation ade completed)	(Give I	ent's Usual Occu	during most of wo	rking	16b. Kind of Bus	siness/Industry
2121		Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. D	ONOT use retire	ed)		1 mats	untion)
d 2	Hygie bther ent, II	0	17. Father's Name (First, Middle, Las.	")	h-1	10000	1	me (First, Middle,	007.0	-000
Maryland	ges 1 and 2 should be filed withir t of Health and Mental Hygiene. If tiem 27 Is marked other than or other traumatic event, the Market	To B	Unknown				Loi	use cl	LEMON	
Man	2 sho and I Is ma raums		19a. Informant's Name/Relationship	196	19b. Mailing		t and Number or R			
	is 1 and of Health item 27 other to		20a. Method of Disposition	es-Wye	Place of Dispos	sition (Name of latory or other pla	tico ME	BAHO L		City or Town, State
nor	ages ant of it: If it y or o		1 ☐ Burial 2 ☑ Cremation 3 [ 4 ☐ Donation 5 ☐ Other (Speci		Citiza C	BUST	. 11.	22-05	20 Hz	
Baltimore,	permit. Pages Department of Important: If i any Injury or once.		21. Signature of Funeral Service Lice		22.	Name and Ad	e is of Facility  18- Fun S  512 Fre D  19 ing. such as cardia	PA	DA ITO	1-10
Ö	Depa Impo any l		Michael 3	igher		cheel Lig	SIZ Fred	erich A	E BALLO	MD. 21229
i są			23a. Part1. Enter the disease, or conshock, or heart failure. List only	polications that caused the dea one cause on each line.	ath. Do not ente	r the mode of dy	ng, such as cardia	c or respiratory ar	rest,	Approximate Interval Between Onset and Death
7	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Kospir	ator	J- +	ailur	e		Onsot and Board
	Examiner		1	Due to (or als a conse	iquence of):	ia				
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a conse						
	ecuted and I-transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c						
8760,			resulting in death, Last	Due to (or as a conse	quence of):					
687	ate hys	edical		d						
Box (	eath certific attending pi	n/Me	fF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregr		F-1			23d. Date	of delivery
	0 0 0	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fel 4 ☐ Pregnant at time of 9 ☐ Unknown		Ectopic pregnance Other (specify) _	;y		Mon	th Day Year
P.0	that the de ed by the detached		9 ☐ Unknown  Part II. Dther significant conditions		sulting in the un	iderlying cause or	ven in Part I	23e Did to	phaceo use contri	bute to the cause of death?
Vital Records,	8 50	d by	, c., <u>-</u>		security are are	activity and accept gr	YOU IT I GIT I.			3 ☐ Probably 4 Minknown
00	law requir as been si 2 should l	Completed						24a. Was	an 24b. W	ere autopsy findings available
R	و يَبُ و	mo						autop perfor	sy pr med? de 2 <b>25</b> No 1[	ere autopsy findings available for to completion of cause of eath?
/ita	ysician: The is certificate director, pag	Bec	25. Was case referred to medical examiner?					ath (Check only o		
of \	% ≤ <del>5</del>	2	1 ☐ Yes 2 ☑ No  27. Manyer of Death	1	ER/Outpatient	JLI DOA		Home 5 Resid		
on	ding After fune	tlon	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	28c. Inju Wo	nyat ork? ]Yes 2∐No	280. Describe r	ow injury occurre	d
Division of	Attend or death ector: / by the f	Certification:	3 Suicide 6 Could not lead to determine	De Bloom of leiver At	home, farm, stre	et, factory, office		28f. Location (S City or Tow	treet and Number	r or Rural Route Number,
ā	ital or rs afte al Dir led in	Cert	4 E HOMBIO	building, etc. (3pec	:iiy)			City or Tow	m, State)	
	To the Hospital or Attenwithin 24 hours after deating the Funeral Director: completely filled in by the	edical	29a. Certifier 1 Certifying P (Check only one)	hysician: To the best of my kr miner: On the basis of examin	nowledge, death nation and/or inv	occurred at the t estigation, in my	ime, date and place opinion, death occ	e, and due to the ourred at the time,	cause(s) and man	ner as stated. nd due to the cause(s)
	within 2 To the comple	Med	29b. Signature and title of certifier	and manner stated.		29c. Licen	se number		29d. Date signed	(Month, Day, Year)
	r s ⊢ ŏ		Mill	tono	•		0036			
6			30. Name and address of person who	completed cause of death (Ite	em 23a) (Type, F	Print)	x I x r	1 1	1 0	ber 19, 2005 oad
			Patricia M	le Hon Mu	2	St	01 01.	d l'ou	VTR	000
7	Sta Registr	-	31. Date filed (Month, Day, Year)	2005 32. Redistrar's Sign	nature	back				

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Touristic Boundary Violation (New Year Control of Contr		Dhysisi		Decedent's Name (First, Middle, Last)						Year	
Second   Control   Contr				Emma Viola Keyser							- 00 45 M
Security Number   Passed   P	7	Examin	er		L	4b. City, Town	n, or Location	of Death	//	/	Douldal
Use a present of the control of the		Funeval	Щ		s. last birthday)			24 Hrs. 8. Date of Bit		9. Birthpl	lace (State or Foreign
Total part   Tot				10 M alek		Months Day	ys Hours	Min. 08/06,	71921	Count	try)
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Security   Company   Com	36.	or Ite	y Fu	1 ☐ Never Married 2 🛣 Married 1 ☐ Yes 2 🛣 No							
Security   Company   Com	8	hours tural',			16a Dece	dent's Usual Oc	cupation			VV J.1	
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All Donation S, JOhne (Specify)   Claim Raven Mem PR 11/17/OS GIEN Burnie, MD   21122		Heall tem 2 other			Place of Dispo	sition (Name of					
Agrovimate Autority of Part I. Exter the Assass, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, plant and address or completations and the seath. Do not enter the mode of dying, such as cardiac or respiratory arrest, plant and address or completations and an actions. List only one cause on each fine.  The proposed of the property of	, E	Pages ent of nt: If i		1 X Burial 2 □ Cremation 3 □ Removal from State  '4 □ Donation 5 □ Other (Specify)	-			11/17/05	Glen B	urni	e, MD
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Trys cicking   County   Coun					ath. Do not en	ter the mode of o	tying, such as	cardiac or respiratory a	rrest,		Interval Between
Sequentially list conditions.    Family   Sequentially list conditions   Sequentially list co				disease or condition resulting in death)	ung	mara	leal	inferela	=		/wk
Due to (or as a consequence of):    Due to (or as a consequence of):				Due to (or as a conse	equence						wany
Due to (or as a consequence of):    Due to (or as a consequence of):		19	Jer	Sequentially list conditions, if any, leading to immediate  Due to (or as a cons	rumice of):	ane of	z ca	signe.			years
Due to (or as a consequence of):    Due to (or as a consequence of):		cuted nd ransit	amtr	cause. Enter Underlying Cause (Disease or injury that initiated events  c.	5						
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FFEMALE:     FFEMALE:	876	cate b physic the b	dlca	d							
O'C 4 SPUTONOWN  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  1 Yes 2 No 3 Probably 4 Unknown  24a. Was an autopsy findings available prior to completion of cause of death?  25. Was case referred to medical examiner?  1 Yes 2 No 3 Probably 4 Unknown  24b. Were autopsy findings available prior to completion of cause of death?  25. Was case referred to medical examiner?  10 Yes 2 No 3 Probably 4 Unknown  25. Was case referred to medical examiner?  26. Place of Death (Check only one)  27. Manner of Death (Specify)  28b. Date of Injury (Mont), Day Year)  10 Yes 2 No  28b. Date of Injury (Mont), Day Year)  29a. Centrier (Check only one)  29a. Centrier (Check only one)  29b. Signature and title of centrifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of centrifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29c. License number  29d. Date signed (Month, Day, Year)  1// 3/OS  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)		certifi nding	/Me	23c It vas outcome of pred	nancy				23d. Date	of delive	rv
Second   S	Bo	death a atter d for u	iclar	in the past 12 months?							•
Total   Section   Sectio	0	the by the	hys								
24a. Was an autopsy performed?  1   Yes   2   No  25. Was case referred to medical examiner?  26. Place of Death (Check only one)  27. Manner of Death  1   Check only one)  28. Date of Injury At home, farm, street, factory, office  28. Place of Death (Check only one)  28. Date of Injury At home, farm, street, factory, office  28. Place of Death (Check only one)  28. Date of Injury At home, farm, street, factory, office  28. Place of Death (Check only one)  28. Date of Injury At home, farm, street, factory, office  28. Place of Injury - At home, farm, street, factory, office  28. Place of Injury - At home, farm, street, factory, office  28. Place of Injury - At home, farm, street, factory, office  28. Place of Injury - At home, farm, street, factory, office  28. Place of Injury - At home, farm, street, factory, office  28. Place of Injury - At home, farm, street, factory, office  28. Coalion (Street and Number or Rural Route Number, City or Town, State)  29. Signature and title of partifier  29. Signature and title of partifier  29. Date signed (Month, Day, Year)  11/13/05  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  24. Was an autopsy perior to complete of cause of death (Item 23a) (Type, Print)  29. Church of the street and Number or Rural Route Number, City or Town, State)  29. Church of the street and Number or Rural Route Number, City or Town, State)  29. Church of the street and Number or Rural Route Number, City or Town, State)  29. Church of the street and Number or Rural Route Number, City or Town, State)  29. Church of the street and Number or Rural Route Number, City or Town, State)  29. Church of the street and Number or Rural Route Number, City or Town, State)  29. Church of the street and Number or Rural Route Number, City or Town, State)  29. Church of the street and Number or Rural Route Number, City or Town, State)  29. Church of the street and Number or Rural Route Number, City or Town, State)  29. Church of the street and Number or Rural Route Number,		es thi		Part II. Other significant conditions contributing to death but not re	_		•		_		
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26. Place of Death (Check only one)  27. Manner of Death 1	3ec	e la has	mple					auto	psv o	rior to com	isy findings available npletion of cause of
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29a. Certifier (Check only one)  29b. Signature and title of certifier  29b. Signature and detection who completed cause of death (Item 23a) (Type, Print)  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  1//13/05  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	ion	ath. or: Aft	atlo	2 Accident investigation	injury			No			
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  William Devices Control World Month, Day, Year)  31. Date filed (Month, Day, Year)  32. Register's Signature  NOV 2 2 2 105				· Clearen		De	2014	147	11/1	3/0	5
State Registrar  NOV 2 2 2005  MON 2 2 2005	(	1		30. Name and address of person who completed cause of death (It	em 23a) (Type,	Print)		.(	3.5	0	(
Registrar NOV 2 2 2005 \ Appell	6	2		31 Date filed (Month Day Year) 22 Pariet Pariet	TO \	MAROS	- Me	ENJOAL C	ELETRI		MJ
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Amend item#18, per H1, C849, 11/22/05 TT State of Maryland / Department of Health and Mental Hygien@ [] 5 For State Registral Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Miriam Ruth King 20,2005 November 6:35 P. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 111 Hamlet Hill Road Apt.812 Baltimore N/A| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | May 14,1921 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□ M 2 F 099-18-1240 84 Director Yrs New York, N.Y. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location worls 10d. Inside City Limits item 27 is marked other then "neturel", or Items 23e or 28e-f show other treumetic event, it is McCleal Examinar in the be mailled at Completed by Funeral Director 1∭Yes 2□No Maryland N/ABaltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 111 Hamlet Hill Road 21210 Apt.812 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ÈYes 2 □ No If Yes, Give Year or Dates: ₩ • ₩ • 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after or nent of Health and Mental Hygiene. nnt: If item 27 is marked other then "neturel", or Iter Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 HNo White W.W.II Specify: 3 →Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 04 Home Maker Own Home 18. Mother's Name (First, Middle, Maiden Sumame)
Rockman
Hermina Rechman 17. Father's Name (First, Middle, Last) Be Lawrence Schiller 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Justin J. King (Son) 620 Murdock Road Baltimore, Maryland 21212 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ò Department of Importent: If eny injury or once. Evans Funeral Chapel 11/2/2005 Forest Hill, Maryland <sup>¹</sup> 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Peaceful, Alternatives Funeral Cremation Ctr., P.A 2325 York Road Timonium, Maryland 21093 Enter he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 2000 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Disalto (or se a conesquence of) Physiclan/Medical Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-transit or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. physician the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? ģ Month Day Year 4 Pregnant at time of death P.O. 5 Other (specify) the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by 9 3 Probably 4 Inknown 1 ☐ Yes 2 ☐ No director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 20 No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 1 ☐ Yes 2 No 5. Residence 6 □Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 ☐ Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 ☐ Homicide within 24 hours a 12 Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) ပ 21 JOV State Registrar

State of Maryland / Department of Health and Mental Hygiene. Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death NOVEMBER 19, 2005 **Physician** EDWARD H. KNELLER 7:45 a. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 1236 DEANWOOD ROAD PARKVILLE BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6/1/1934 Funeral 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Months Hours 1 M 2 □ F 215-30-7566 71 Yrs. MARYLAND Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c, City, Town or Location Item 27 is marked other than "naturel", or Itema 23e or 28a-f show other traumatic event, it a Madical Examination manual be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 😾 No BALTIMORE PARKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1236 DEANWOOD ROAD 21234 Funerai USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene. 1 ☐ Never Married 2√7 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry lementary/Secondary (0-12) College (1-4or 5+) 8th GRADE TRUCK DRIVER CAUSTAR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) BURTRAM KNELLER NETTIE HOOT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is rr any injury or other traum 2002. FRAN KNELLER/WIFE 1236 DEANWOOD ROAD BALTO., MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY INC. 11/22/05 CATONSVILLE, MD 22. Name and Address of Facility THE JOHNSON FUNERAL HOME P.A. 21. Signature of Funeral Service Licensee 8521 LOCH RAVEN BLVD. TOWSON, MARYLAND 21286 23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cau hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner certificate be executed use as the burial-transit resulting in death) Last Due to (or as a consequence of): attending physician Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe this certificate 1 🗌 Yes 2 No 1 Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 Tes 2 No 1 🗌 fnpatient 5 ☐ Residence 6 ☐ Other (Specify) 4 Nursing Home 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 28b. Time of Injury at Work? After Natural 5 Pendina hours after death. 2 Accident investigation М 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature 29d. Date signed (Month, Day, Year) 0 31. Date filed (Month, Day, Year) State Registrar

Amend Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#11, perFh\_G849\_11-28-05\_TT

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrat Reg 200 0 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 6:00a M Joseph LIVErman 14 05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 236 Sandhill Road Essex Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours **№** M 2 🗆 F NorthCarolina 231-26-5145 79 Director Jan 4,1926 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28s-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other than "netural", or items 23s or 28s-f ehow any injury or other traumatic event, tra Medical Exactions must be notified alonge. MD Baltimore Essex 1 Yes 2X No Director 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 236 Sandhill Road 21221 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ Yoo Specify: Specify.White 3-₩idowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Beth Steel Steel Worker 8th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Johnny Liverman Della Dunbar 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Katie Liverman /wife 236 Sandhill Road Baltimore MD 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location · City or Town, State 1

☐ Burial 2 ☐ Cremation 3 ☐ Removal from State HollyHillCemetery 11/16/05 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility ConnellyFuneralHomeofEssex 21. Signature of Funeral Service Licensee me 300 Mace Ave. Baltimore MD 21221 Part1. Enter the disease, or completations that caused the death, shock, or hear failure. List any one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** facture /Medical Due to (or as a consequence of): Examiner Ischemic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner as the burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of) been signed by the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No page 2 should be detached Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has autopsy 1 ☐ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifice Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ဥ 28c, Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Zu Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal (Check unity one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Vas M. D 11/16/05 145876 30. Name an laddre's of person who completed cause of death (Item 23a) (Type, Print) campbell 4920 Blud Ltemore

State Registrar 31. Date filed (Month, Day, Year)

Joseph

Registrar's Signature

		For	State of Marylan		rtment of H			71115	37609
	X	Registrar  1. Decedent's Name (First, Middle, Las				Death	2. Date of Dea	ath Day Year	3. Time of Death
Physic /Medi			Cynthia G.	Ledfo		r Location of Death	Novem		
Exami	ner	4a. Facility Name (If not institution, give	Ne Hospita		Rose	edale		Bal	Fimore
Funeral		5. Social Security Number 6. Sec 212-46-9396	7. Age (In yrs. )		If Under 1 Year Months Days	Hours Min.	8. Date of Birt (Month, Day Sept.	v. Year) Co	thplace (State or Foreign ountry)
Director		Usual Residence of Decedent		y, Town or Loc	nation				10d. Inside City Limits
ith the Marylar or 28a-f show	tor	MD Balti		Essex					1 Yes 2 XNo
ith the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What Co	ountry?
leath w	Funeral	504 Mace Ave	12. Was Decedent Ever in U.	S. 13. V	21221 Vas Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	USA 14. Race - Ame	
DESILITIOTE, INICITY ICITY IN A TAIN SOLVED TO PROBLEM.  PERMIT. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at any injury or other traumatic.	by Fun	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give		Yes, specify Cuba  ☐ Yes 2 No	an, Mexican, Puerto Specify:	Rican, etc.)	Black, White Specify: Wh	
2 hour		15. Decedent's Ed	Year or Dates:	16a. Deced	ent's Usual Occup	ation during most of work	rina	16b. Kind of Business	/Industry
within 7 ane. Ithen "r	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		NOT use retired Attenda	during most of work d) ant		Baltimo	re County
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y id i	To B	William Mitt		10h Mailin	a Address /Street			. Allen er, City or Town, State,	Zin Code)
Mar nd 2 st alth and 27 is n r traun		19a. Informant's Name/Relationship (7) William Ledf						MD 21221	Lip Code)
or other		20a. Method of Disposition  1 XBurial 2 Cremation 3	20b. P	lace of Dispos	sition (Name of natory or other place)		Date / 23 / 05	20c. Location - City or	
Dallimo Dermit. Pages Department of mportant: if i any injury or once.		4 □Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen	)		. Name and Addre	es of Eacility			
Depa impo impo any io		1 R. Terry	omiell			e Ave.	Baltim	roe MD 21	
	Ď.	23a. Part1. Enter the disease, or composhock, or heart failure. List only of Immediate Cause (Final	dications that caused the death	Do not ente	er the mode of dyir	ng, such as cardiac	or respiratory ar	rest,	Approximate Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	a. Due to (or as a conseq	uence of):	e a	njury			
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ate be executed hysicien and the burial-transit	Ical Ex	resulting in death) Last	Due to (or as a conseq	uence of):					
Certificate ding physise as the	9	IF FEMALE:	d						
or its as a	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1□Live birth 2 □Feta 4□Pregnant at time of d	Ideath 3□	Ectopic pregnancy Other (specify)	<b>y</b>		23d. Date of de Month	livery Day Year
cy the achec	hysi	1 Yes 2 No 9 Unknown	9□ Unknown				an Did	obacco use contribute to	a the proves of death?
<b>v</b> 8 5 8	Ď	Part II. Other significant conditions of	ontributing to death but not res	ulting in the ur	iderlying cause giv	en in Part I.	23 <b>9</b> . Dia 10	V	robably 4 Unknown
	Completed						24a. Was	an 24b. Were a	utopsy findings available completion of cause of
The The ete h							perfo	rmed? death? 2. No 1 Yes	s 2 No
Or VITAL Physicien: The Physicien: The Physicien: The Physicien of this certificete ral director, pag	To Be	25. Was case referred to medical examiner?  1 Yes 25 No	Hospital:	ER/Outpatien	t 3 DOA Ott	26. Place of Deal		<i>ine)</i> dence 6 □Other ( <i>Spe</i>	ecify)
<b>—</b> 20 30 30 50 €		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor	y at rk?   Yes 2 □ No	28d. Describe	now injury occurred	
Atten r deat ector: by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined				100 2 3 10	28f. Location (S City or Tox	Street and Number or R vn, State)	ural Route Number,
Hospital or Hospital or 24 hours afte Funerel Dir stely filled in			ysician: To the best of my kno		occurred at the til	me, date and place	and due to the	cause(s) and manner a	s stated
To the Hospital of within 24 hours af To the Funerel D completely filled in	Medical	(Check only 2 Medical Exam	niner: On the basis of examina and manner stated.	tion and/or inv	estigation, in my	ppinion, death occur	red at the time,	date and place, and due	e to the cause(s)
To ti withi To ti	Σ	29b. Signature and title of certifier			29c. Licens			29d. Date signed (Mont	
10		30. Name and address of person who	completed cause of death (Item	n 23a) (Type,	Print) Kee	200000		0 11 2	- - Md 2123
1		DR Aduku Or 31. Date filed (Month, Day, Year)	MKOGU 90	00 Fro	ankin 5	Square J	Drive "	Baltinone	-Ma 2123
S Regis	tate trar	NOV 2 2 2005	32. Registrar's Signa	STORE		•			

	4	For State Registrär	State of Maryland / Dep	partment of Health and ertificate of Death	Mental Hygie	ene 2.005	37610
Physiciar /Medica Examine	n il r	Decedent's Name (First, Middle, Last John Leo Lepu     4a. Facility Name (If not institution, give 1603 Bulls Lane	Street and number)	4b. City, Town, or Location of Dea	th	19, 2005  4c. County of Dea	d d
Funeral Director		5. Social Security Number  212-34-8933  Usual Residence of Decedent	x 7. Age (In yrs. last birthda M 2□ F 69 Yrs.	y) If Under 1 Year If Under 24 Hr. Months Days Hours Min		9. Bir , 1936 Ma	thplace (State or Foreig ountry) TYLAND
the Marylan 28e-f show ctified st	ector	10a. State 10b. County  Maryland Harford  10e. Street and Number	10c. City, Town or	DOI. Zip Code	100	g. Citizen of What C	1 Od. Inside City Limits
3a or	5	1603 Bulls Lane		21085	101	U.S.A	-
Jes de la company	by rur	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 【XDivorced	12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes _ 2 M No If Yes, Give Year or Dates:	3. Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Pue  1 □ Yes 2 ☒ No Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - Am Black, Whi	
d within 72 ho giene. or than "natur the Medical	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	COHADA (1-40F5±)	edent's Usual Occupation ve kind of work done during most of we . DO NOT use retired) Manager	orking C.	6b. Kind of Business Losures a	,
id be ental ked c	lo Be C	17. Father's Name (First, Middle, Last) Stephen H. Lep		Helen	A. Lonce	ala	
s 1 and 2 should if Health and Men item 27 is marke other treumetic		19a. Informant's Name/Relationship (T) Mrs. Susan Baer		iling Address (Street and Number or F Longbottom Ct., Ki			
0 = 5		20a. Method of Disposition 1		position (Name of rematory or other place)  eart of Mary 11/		Oc. Location - City or	
permit. Pa Departmen Important: any injury once.		21. Signature of Funeral Service Licens	500	22. Name and Address of Facility S	chimunek F	uneral Ho	
Physician /Medical Examiner be parentled by the parentled	cai Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a consequence of).  Due to (or as a consequence of).  Due to (or as a consequence of).  Due to (or as a consequence of).	vlew suite preumonia		st,	Approximate Interval Between Onset and Death
ath certifica	by Physician/Medica	IE EEMALE:		B⊟Ectopic pregnancy □ Other (specify)		23d. Date of de Month	livery Day Year
w requires that the debeen signed by the should be detached to		Part II. Other significant conditions co	ntributing to death but not resulting in the	underlying cause given in Part I.			o the cause of death?
	Completed				24a. Was an autopsy performe	prior to death?	utopsy findings available completion of cause of s 2 No
cien ector	Re	25. Was case referred to medical examiner?	Hospital:		ath (Check only one)		
hys his	ation: 10	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a Date of Injury (Month, Day Year)  28b. Time Injury	of 28c. Injury at	Home 5 Residen 28d. Describe how		ecify)
To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury · At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stre City or Town,	et and Number or R State)	ural Route Number,
To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical	29a. Certifier (Check only one)  1 Certifying Phy 2 Medical Exam	rsician: To the best of my knowledge, de iner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place investigation, in my opinion, death occ	e, and due to the cau surred at the time, date	ise(s) and manner a e and place, and du	s stated. e to the cause(s)
To the within To the comple	Me	29b. Signature and title of pertifier	h-	29c. License number	290	d. Date signed (Mont	th, Day, Year)
12		30. Name and address person who co	ompleted cause of death (Item 23a) (Typ	DS2749  a. Print)  OSILV Driv	TWIN	mo 21	204
State Registra		31. Date filed (Month, Day, Year)	32. Registrar's Signature	USINY BY	104-30-4		·

DHMH 17 Rev 1/2001

ORIGINAL

		For State Registrar	State of Man		artment of rtificate o			giene 05	37611
Physic /Medi			STEPHEN C	. LOVE	-		2. Date of Dea Month 11 -	18 - 2005	
Examir	er	4a. Facility Name (If not institution, give HOSPICE OF BALTIMO)  5. Social Security Number 6. Sex	RE GILCHRIS	T CENTER		OWSON  If Under 24			LTIMORE
Funeral Director				79 Yrs.	Months Day		Hrs. 8. Date of Birth (Month, Day 06-30-1	1926	Birthplace (State or Foreign Country) MARYLAND
e Marylan 3e-f ehow iilled at	ctor	MD. 10b. County N/A	1	0c. City, Town or Lo	BALTI	MORE C	CITY		10d. Inside City Limits  1\n\n\n\Y\Yes 2 □ No
eth with th	ral Director	10e. Street and Number 2707 FLEETWOOD	AVENUE		10f. Zip Code	21214		10g. Citizen of What U.S.	•
0036 nours after deeth with the Marylan aral', or items 23s or 28e-f ehow Examinar must be politied at	d by Funeral	11. Marital Status  1  Never Married XX Marned 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? XXYes 2 ☐ No If Yes, Give Year or Dates:	1944-	Was Decedent of Yes, specify Cu		? (Specify Yes or No- uerto Rican, etc.)	14. Race - Al Black, W Specify:	merican Indian, hite, etc. WHITE
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Pyglene. Importent: If item 27 is marked other than "natural", or items 23a or 28e-f ehow appring or other traumatic event, the Medical Examinar must be positived at once.	Completed	15. Decedent's Edu (Specify only highest grade		(Give	dent's Usual Occ kind of work dor DO NOT use reti PLUMBER	ne during most of	working	16b. Kind of Busine	
faryland 2 should be fill and Mental Hy Is marked oth	To Be			VERDE		JU	Name (First, Middle, ILIA SOLA	ARO .	
e, Mar land 2 sh lealth and m 27 Is m her traum		19a. tnformant's Name/Relationship (Ty, MARY A. LOVERDE	(WIFE)	2707	FLEETWO		and the same of	DRE, MARYL	AND, 21214
Saltimore, ermit. Pages 1 ar Beparlment of Hea mportent: If Item: in yinjury or other ince.		20a. Method of Disposition  X ☑ Burial 2 ☐ Cremation 3 ☐ R  4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	DULANEY V	ALLEY M	EM.G. 11			MARYLAND,2109
Baft permit. Departr Import	Tito)	21. Signature of Funeral Survice License  23a. Part1. Enter the disease, or compli	(R. G.	RUTH) RU		ON FUNER	AL HOME, IN	100000	,MD.21204
Physician /Medical Examiner and ine pural-transit in physician and interpretation and int	dical Examiner	shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	onsequence of):	,	igna			Approximate Interval Between Onset and Death Want Thy
vision of Vital Records, P.O. Box 68760, attending Physician: The law requires that the death certificate be executed refeath. etch: Attent his certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of p 1 Live birth 2 C 4 Pregnant at tim 9 Unknown	Fetal death 3	Ectopic pregnan	ncy		23d. Date of o	lelivery Day Year
cords, P wrequires that been signed b	d by Pl	Part II. Other significant conditions con Dementi	tributing to death but n	ot resulting in the un	nderlying cause o	given in Part I.	23e. Did tol	1.	to the cause of death?  Probably 4 ☐Unknown
Vital Records, aician: The law requires the certificate has been signe rector, page 2 should be certificate.							24a. Was a autops perforr 1 🗆 Yes	ned? death 2 No 1 □ Y	autopsy findings available o completion of cause of ?
Division of Vita and reducing Physician: alter death Director Alter this certific in by the funeral director,	Certification: To Be	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	ospital: 1	2 ER/Outpatien 28b. Time of Injury	28c. lnj	ther: 4 Nursin	Death Check only on ig Home 5 Reside 28d. Describe ho		ocity) to spice
DIVIS Hospitel or Att 4 hours after de Funerel Direct tely filled in by t		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of tnjury building, etc. (5				City or Town	n, State)	Rural Route Number,
Divisio  To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the ft	Medical	one)	ician: To the best of mer: On the basis of exand manner stated	amination and/or inv	estigation, in my	opinion, death o	ccurred at the time, d	ate and place, and d	ue to the cause(s)
6 € € 6 6	4	29b. Signature and title of certifier  30. Name and address of person who co	Rolly	(Item 232) Time	29c. Licer	S 205	-   2	9d. Date signed (Mo. Vovenlu	nth, Day, Year)  2 / E 200 J
Sta	10	31. Date filed (Month, Day, Year)			Charle	, St. 4.	selfo m	d 2,2	o k
Registr				K	South !				

			1 - For State Registrer	State of M		partment of e <i>rtificate o</i>	Health and M f Death		ene 2005	37612
	Physici /Medic		1. Decedent's Name (First, Middle,	1	arman			2. Date of Death Month	Day Year	3. Time of Death 7,25 PM
	Examir		4a. Facility Name (If not institution,				, or Location of Death	77000	4c. County of Death	
	Funeral Director		VA Rehabilitation 5. Social Security Number 051-22-9560		ed Care .ge (In yrs. last birthda 74 Yrs.		s Hours Min.	8. Date of Birth (Month, Day, Y	/ear) 9. Birth Cou	place (State or Foreign ntry) NY
	show	<u>.</u>	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	ith the Ma or 28a-f	Director	MD Balt  10e. Street and Number	imore	Owin	ngs Mills 10f. Zip Code		10g	g. Citizen of What Cou	1 ☐ Yes 2 No
936	hours after death with the Maryland tural', or Items 23a or 28a-f show all Ever it set matter resition at	by Funeral	5 Pleasant Rid; 11. Marital Status 1 □ Never Married 2 Marrie 3 □ Widowed 4 □ Divorced	12. Was Deceden Armed Forces	? ]No		1117 f Hispanic Origin? (Spruban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	USA  14. Race - Ameri Black, White, Specify:	etc.
Maryland 21215-0036	I within 72 hours liene r than "natural", the Madical Eve	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)		(Gi	. DO NOT use reti	ne during most of worki red)	ing 16	Whi bb. Kind of Business/In	dustry
land 2	be filed ital Hyg id othe event,	To Be Co	12 17. Father's Name (First, Middle, La Bertram Learma	•		Police Of	18. Mother's Name	e (First, Middle, Ma		orcement
	nd 2 shallth and 27 ls m	_	19a. Informant's Name/Relationship Shirley A. Learn	(Type, Print)			et and Number or Rura		e <u>Cater</u> City or Town, State, Zip s Mills, MI	
Baltimore,	Pages 1 au nent of Hea int: If item iry or othe		20a. Method of Disposition  1 □ Burial 2 ☑ Cremation 3  4 □ Donation 5 □ Other (Spe	☐Removal from State	20b. Place of Dis cemetery, ci	position (Name of rematory or other p	lace)	Date 20	c. Location - City or To	own, State
Balti	permit. Pages. Department of H Important: If ite any injury or of		21. Signature of Funeral Service Lie			Cremation 22. Name and Add Eline Fu		11824	lampstead, Reistersto erstown, MI	own Road
	Physician		23a. Part1. Enter the disease, or conshock, or heart failure. List or Immediate Cause (Final disease or condition	A .1 .	d the death. Do not eline.	nter the mode of dy		or respiratory arrest	,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)  Sequentially list conditions	Due to (or as	s a consequence of):					
8760,	cate be executed physician and the burial-transit	al Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	s a consequence of): s a consequence of):					
.O. Box 687	death certifi e attending id for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death 3	□Ectopic pregnan	су		23d. Date of delive	ery Day Year
rds, P.	sign d be	by	Part II. Other significant conditions	s contributing to death I	out not resulting in the	underlying cause g	iven in Part I.		co use contribute to the	. /
al Records,	The taw ate has b page 2 sl	Completed						24a. Was an autopsy performed	prior to cor death?	psy findings available inpletion of cause of 2 No
ion of Vital	ding Phys h. After this funeral di	atlon: To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Man of Death 1 Natural 5 Pending 2 Accident investigat	Hospital: 1 Inpati 28a. Date of Inju (Month, Da	ury 28b. Time	of 28c. inju			e 6 ⊡Other (Specify injury occurred	)
Division		Certification:	3 Suicide 6 Could not determine	a 286. Place of in	jury - At home, farm, s tc. (Specify)	treet, factory, office	2	8f. Location (Stree City or Town, S	t and Number or Rura tate)	l Route Number,
	To the Hospital or Atten within 24 hours after deat To the Funeral Diractor: completely filled in by the	Medical (	one)	Physician: To the best aminer: On the basis of and manner st	i examination and/or i	th occurred at the t	ime, date and place, a opinion, death occurre	nd due to the caused at the time, date	e(s) and manner as st and place, and due to	ated. the cause(s)
X.	To the To the Complet		29b. Signature and title of certifier  20. Name and address of person where the control of the c	E. Will	L型 17	D, 29c. Licen	(1365	No.	Date signed (Month, I	( 2025
10						Print) Loch Ra	ven Boul	evand, B	alternove,	MD 21218
*	Sta Registra		31. Date filed (Month, Day, Year)		rar's Signature	north)				

**ORIGINAL** 

MARY

LINNS

761	.0		ricase	State of	Maryland / Dep	artment of He	alth and M	fental Uv	are Leg	ible.	7611		
			1 - For State Registrar		Ce	ertificate of De	eath		Reg. No.	5 3	17614		
7	Physici	an	Decedent's Name (First, Middle, L		JISE L. LADS	ON		2. Date of De Month	Day	Year	3. Time of Death		
	/Medi	cal	4a. Facility Name (If not institution, g.			4b. City, Town, or Lo	antion of Dooth	Novemb		2005	9:46 P		
	Examir	ner			oer)				4c. Count	y of Death			
	Funeral	- Sign -	Johns Hopkins H 5. Social Security Number 6.		. Age (In yrs. last birthda)		imore f Under 24 Hrs.	8. Date of Bir	th	N/A	lace (State or Foreign		
100	Director		217-82-2490	1 □ M 2 <b>X</b> F	96 Yrs.		Hours Min.	(Month, Da	y, Year) 0, <b>1909</b>				
	Р.		Usual Residence of Decedent					Aug I	0, 1000				
	unylar show	_	10a. State 10b. County		10c. City, Town or I				10d. Inside City Li				
	8a-f	50	MD.			BALII	MORE				1 X Yes 2 □ No		
	with th	Director	10e. Street and Number 2237 CECIL AVE.			10f. Zip Code	04040		10g. Citizen of		-		
	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or items 23s or 28s-f show event, the Medical Exeminar mination in difficular.			10 144 - 0			21218		1 =	U.S.A			
	er de	Funerai	11. Marital Status	12. Was Deced	ent Ever in U.S. 13	Was Decedent of Hispa If Yes, specify Cuban, I	anic Origin? (Spi Mexican, Puerto	- 14. Ra Bla	ce - America ck, White, e				
36	irs af	by	1 X Never Married 2 Married 3 Widowed 4 Divorced	If Yes, Give		1 ☐ Yes 2 🛣 No S	Specify:		Speci	fy: B	lack		
9	2 hou	ed	15. Decedent's 1	Education	16a. Dec	edent's Usual Occupatio	าก		16b. Kind of E	Business/Ind	lustry		
215	hin 7	pie	(Specify only highest g Elementary/Secondary (0-12)	rade completed)  College (1	life	e kind of work done duri DO NOT use retired)	ing most of work	ing			•		
21	d wit	Completed	NA NA	Conogo (1	101 017	HOUSE	MAKER			DOMES	STIC		
힏	be filed tal Hygid d other	Be C	17. Father's Name (First, Middle, Las			18	. Mother's Name	(First, Middle,	Maiden Suma	me)			
<u>yla</u>		ို		INK		MORIAH							
Maryland 21215-0036		77	19a. Informant's Name/Relationship	-	ing Address (Street and			-	, State, Zip	Code)			
	s 1 and f Health itam 27 other tr		FLORA LADSON NIE			237 CECIL AVE							
Baltimore,			20a. Method of Disposition 1 🗷 Buriar /2 ☐ Cremation 3	ale	ematory or other place)		Date	20c. Location					
Ë		1 8	4 Donation 5 Other (Spec			ZION CEMETER	•	11/17/05	ľ	MARYLAND			
Bal	permit. Departn Imports any inju		21. Signature Fune of Service Lo	ensee	1	2. Name and Address o MILLER'S	of Facility METROPO	I ITAN CH	APFI P				
~ .	3,7		23a. Part1. Enter the disease of cor	polications that car	used the death. Do not en	1639 NOR	TH BROAD	)WAY BAL	TIMORE.	MARYL			
26			snock, or near Lawure, List on	y one cause on ea	on line.						Approximate Interval Between Onset and Death		
}	Physician /Medical	1	Immediate Gause (Final disease or condition resulting in death)		unsclenot	7 [arou	uvasu	Fir a	186486	_			
	Examiner			Due to (o	r as a consequence of);								
		e.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (o	r as a consequence of):								
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events										
oʻ.	sicien and burial-transit	Exa	resulting in death) Last	Due to (o	as a consequence of):								
760,		cai		d									
9	leath certificat attending phy I for use as the	ledi	IF FEATURE										
Box	th cer tendir r use	an/\	IF FEMALE: 23b. Was decedent pregnant		ome of pregnancy h 2 Detail death 3	☐Ectopic pregnancy			1	ite of delive	•		
	s dea he att	sici	in the past 12 months?		nt at time of death 5	Other (specify)			Mo	onth	Day Year		
P.0	that the de ed by the detached	Physician/Med	9 Unknown				<del></del>						
	res th	þ	Part II. Other significant conditions	contributing to dea	th but not resulting in the	underlying cause given in	n Part I.				cause of death?		
Records,	v requir been si should	Completed						1 1 1	'es 2□No	3   Proba	ibly 4 Unknown		
ec	elaw hasb je 2 sl	n pie						24a. Was autop	sy	Were autop	sy findings available		
<u>=</u>		S						perfor		death? 1 ☐ Yes :	2 No		
Vital	sicien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Unneitali	V		6. Place of Death	Check only o	ne)				
of	d is	2	1-1 Yes 2 □ No	Hospital:			4 Nursing Hor				)		
Ü.	fing f	ion	27 Manner of Death  1 Avatural 5 Pending		Injury 28b. Time of Day Year) Injury	Work?		28d. Describe h	ow injury occur	red			
<u>:</u>	Attending r death. ector: After by the funer	ical	2 Accident investigation 3 Suicide 6 Could not	De Olean e	f Injury - At home, farm, si		2 No	196 Location /6	troops and Mirror				
Division	or A after Direct	Certification:	4 Homicide determined	building	, etc. (Specify)	reet, ractory, office	-	City or Tow	n, State)	oer or Hurai	Route Number,		
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: Atter th completely filled in by the funeral		29a. Certifier 1 ☐ Certifying P	hysician: To the h	est of my knowledge, dea	th occurred at the time	date and place	and due to the	m bac (a) April S	anner as sis	ted		
	Ho:     Z4 h     Fur     letely	Medical	(Check only a Medical Exa	miner: On the bas and manne	is of examination and/or ii	vestigation, in my opinio	on, death occurre	ed at the time,	date and place,	and due to	the cause(s)		
	To the within 2 To the complet	Me	29b. Signature and title of certifier	. 1	æ	29c. License nu	ımber		29d. Date signe	d (Month, D	lay, Year)		
			> Coline	art		O.C.	M.E.	11941	Novembe	r 11.	2005		
	M		30. Name and address of person who	completed cause	of death (Item 23a) (Type	, Print)							
		4, 2,	UTISTUC	LAA !	/1-1	Penn Street	, Balti	more. M	aryland	2120	1		
	Sta Registr		31. Date filed (Month, Day, Year)	32. Reg	jistrar's Signature								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienen 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month ( Year **Physician** CACANFORA 20 2008 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner BALTIMORE Johns Hopkins Bayview Med Ctr If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Min. 1 M 2□F Hours 218-01-6571 TUNC Director Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 10a State 10b. County ed other than "naturel", or items 23a or 28a-f show event, the Medical Examiner must be notified at VYes 2 No Director HIMORE MARYLAND 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1300 5 LWOOD or items 23a HUENGE 21224 deeth v Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. If them 27 is marked other than "naturel", or itement fillury or other traumatic. Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify. þ 3 Widowed 4 Divorced Completed 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8+1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumame) Be CANFORA 2 enede 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S 327 Ave. FORA 20b. Place of Disposition (Name of 20c. Location Date 20a. Method of Disposition cemetery, crematory 1 Burial 2 Temation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature Fueral Service Licensee 22. Name and Address of Facility Approximate Interval Between Onset and Death 2 a. Part1. Enter the disease sheet, or heart failure. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, is not one cause on each line. List Immediate Cause (Final disease or condition resulting in death) Pnysician RESPIRATORY /Medical Due to (or as a consequence of) Examiner ULMONAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit Due to (or as a consequence of): P.O. Box 68760. the attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ò in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? page 2 should be 3 □ Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy certificate 2/1 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Other 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 ☐ Yes 2/2/No 1 Inpatient 2 ER/Outpatient 3□ DQA 28a. Date of Injury (Month, Day Year) completely filled in by the funeral 27. Manner of Deall 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: Injury 1 Natural 5 Pending 2 No 2 ☐ Accident investigation 1 Yes 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide determined

Division of Vital Records,

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

RUPALI 31. Date filed (Month, Day, Year)

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

RES-000

t Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HADHA

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EASTERN AUE BALTIMONE, 41221224

32. Registrar Signature 2005

			1 - For State Registrar	State of M	larylan		artment of F rtificate of		nd Mer		0 0 5	37616
		z)	1. Decedent's Name (First, Middle, L.	ast)						Date of Death	Day Vari	3. Time of Death
П	Physici /Medio		Jacob Levine						No	Month Ovember	19, 2005	4:30 A. M
	Examin		4a. Facility Name (If not institution, gi	ve street and number	)		4b. City, Town, o	r Location of [	Death		4c. County of De	
٠			Riderwood Village	Renaissa	nce G	ardens	Silver S	Spring			Prince G	eorge!s
	Funeral		Social Security Number     6.	Sex 7. A		last birthday)	If Under 1 Year Months Days	If Under 24		Date of Birth (Month, Day, )	9 Ri	rthplace (State or Foreign country)
L	Director		013-12-9203	1 XM 2□F	89	Yrs.	WOILIS Days	riouis	Ap	ril 13	, 1916 Ma	ssachusetts
	pu ,		Usual Residence of Decedent  10a. State 10b. County		10- 0	. T						
	aryta shov	_	Toa. State Tob. County		TUC. CIT	y, Town or Lo	cation					10d. Inside City Limits
	8a-f	ectc	Maryland Montgor	nery	Sil	ver Sp			·-			1 ☐ Yes 2 No
	vith ti	Funeral Director	10e. Street and Number				10f. Zip Code			100	g. Citizen of What C	Country?
	s 23e	ra	3126 Gracefield H				20904				nited Sta	
	er de Item	nue.	11. Marital Status	12. Was Decedent Armed Forces	?	.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin In, Mexican, F	n? (Specify Puerto Rica	Yes or No- ın, etc.)	14. Race - Am Black, Wh	
36	s aft	by F	1 ☐ Never Married 2 ☆ Married 3 ☐ Widowed 4 ☐ Divorced	1 □ Yes 2 X If Yes, Give Year or Dates:			1 ☐ Yes 2 🗓 No	Specify:			Specify:Wh:	f to
몽	be filed within 72 hours after death with the Maryland ital Hygiene. od other than "natural; or Items 23a or 28a-f show event, the Medical Examination in the routified at	pa k	15. Decedent's E			162 Doco	dent's Usual Occup	ation				
5	in 72 " na Padio	Completed	(Specify onfy highest gi	ade completed)		(Give	kind of work done of DO NOT use retired	ation during most of d)	of working		Sb.Kind of Busines: Inited Sta	•
2	with iene. thar	E C	Elementary/Secondary (0-12)	College (1-4or 4	5+)		istrator	7			Governmen	
Ö	filled Hyg other ent,	Ö	17. Father's Name (First, Middle, Las	")				18. Mother's	s Name (Fil		iden Sumame)	10
a	ould be f Mental I larked of	To Be	Harry Levine					Gussi				
Maryland 21215-0036	is 1 and 2 should be filed within of Health and Mental Hygiene. Ifem 27 la marked other than other traumatic event, ILEM.	-	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address (Street a			<del>-</del>	City or Town, State,	Zip Code)
Š	and 2 saith a n 27 la		Paul Levine/Son								le, MD 20	
<u>6</u>	f Heal f Heal ltem othe		20a. Method of Disposition		20b. P	lace of Dispo	sition (Name of natory or other place	No.	vembe	20	c. Location - City o	Town, State
£	Pages nent of I int: if Its iry or o		1 ☐ Burial 2 [X]Cremation 3 [ '4 ☐ Donation 5 ☐ Other (Speci		'   Moi	ltgome:	rv	١ _	22, 20		a+b1-	M- 1 1
Baltimore,	permit. Pages Department of Important: If II any injury or c		21. Signature Fuleral Service/Lice		<u> </u>	remato:	rium, Inc				ethesda, mphrey Fu	Maryland
ñ	Dep Imp any any		> Wally	L	M013	53 Be	thesda-Cl	hevy Cl Marylar	hase nd 20	Inc. 814-350	7557 Wisc	neral Home/ onsin Avenue
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that cause one cause on each l	d the death	n. Do not ent	er the mode of dyin	g, such as car	rdiac or res	spiratory arres	1,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Attier	osch	when	x/eart 1	18a8				Onse) and Death
	/Medical		resulting in death)	Oue to or as	a consequ	uence of):	_	11 00000			-	- 10010
T	Examiner		Sequentially list conditions	b								2/nh
	φ # g	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequ	uence of):						
¥	ecute and trans	am	that initiated events resulting in death) Last	C								
Š,	icate be executed physician and s the burial-transit	<u> </u>	Tooding in doubly cast	Due to (or as	a consequ	Jence of):						
8/60	cate t	edical	•	d								
×			IF FEMALE:	220 If you guitanne								
X Q	death certific e attending p id for use as f	Physiclan/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 Fetal	death 3	Ectopic pregnancy				23d. Date of de Month	livery Day Year
o.	0 0 0	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∏Pregnant a 9☐Unknown	t time of de	eath 5L	Other (specify)					
ב	law requires that the as been signed by th 2 should be detache		Part II. Other significant conditions	contributing to death t	out not resu	ulting in the ur	nderlying cause give	an in Part I	- T	23e Did tohar	CC USA contribute t	o the cause of death?
ecords,	ires that signed b	1 by	•		, , , , , , , , , , , , , , , , , , , ,	ining at allo of	raonying occose give	or or arti.			2 □ No 3 □ P	. /
0	w require been sig should b	etec							-		2010 001	
ec ec	The law cate has b	Completed						-		24a. Was an autopsy	prior to	utopsy findings available completion of cause of
E E	cate ha									performe 1 □ Yes 2		2 □ No
Vitai	Physician: The this certificate ral director, page	Be	25. Was case referred to medical examiner?	Hospital:			04.		Death (Ch	eck only one)		Leasted
ō	this al dii	70	1 ☐ Yes 2 No  27. Manner of Death	1 Inpati		ER/Outpatien		4 LI Nursir			e 6 Other (Spe	city) Keveney
	on After	lo	Natural 5 Pending	(Month, Da	y Year)	28b. Time of Injury	Work		İ	Describe how	injury occurred	
<u>S</u>	Attending ir death. ector: After by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be	e One Place of In	ium. At ho	mo form str		Yes 2 □No		postion (Ctro		10-14
DIVISION	after Direc	Certification:	4 Homicide determined	building, e	ic. (Specify	')	eet, factory, office			City or Town, S	et and Number or R State)	urai Houte Number,
	spita lours neral filled		29a. Certifier ★ Certifying Pi	nysician: To the best	of my know	wiedge, death	occurred at the tim	e, date and n	place, and o	fue to the caus	e(s) and manner as	stated
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the to	Medical	(Check only 2 Medical Exa	miner: On the basis of and manner st	it examinat	ion and/or inv	estigation, in my op	oinion, death o	occurred at	the time, date	and place, and due	to the cause(s)
	To t Com	Σ	29b. Signature and title of certifier	/			29c. License	number		29d.	Date signed (Mont	h, Day, Year)
			- Talla V 11	ernott			000	4337	5		11/21/15	
	16		(/ 1/	completed cause of o							/	
	13		Karen J. Merrit,	M.D. 3160	Grac	efield	Road, Si	lver S	Spring	, Mary	land 2090	4
	Sta Registr	4	31. Date filed (Month, Day, Year)	32. Fegisti	rars Signal	U A	Road, Si					
	negistr	ત્રા	NOV 2 2	3000								

			For State Registrar	State o	of Marylar	•		nt of Ho te of E		and M		jiene leg. No.	05 3	37617
			1. Decedent's Name (First, Middle, L	ast)							2. Date of Dea Month	th Day	Year	3. Time of Death
	Physici /Medic		EUNICE LOUDEN								November	17	2005	5.27 PM
	Examin		4a. Facility Name (If not institution, g MENCY MEDICAL CER		mber)			Town, or		of Death			unty of Deeth	2
I	Funeral Director		5. Social Security Number 6. 213-20-5884	Sex 1□M 2【ATF	7. Age (In yrs. 80	last birthday) Yrs.	If Unde Months	Days	If Under 2	24 Hrs. Min.	8. Date of Birtl (Month, Day 09-11-19	, Year)	9. Birthp Coun Maryla	
	P >		Usual Residence of Decedent  10a, State 10b, County		10c Cir	ty, Town or Lo	cation						1	0d. Inside City Limits
	anyla shov	٦			100.01	•							Ι'	1 X Yes 2 □ No
	28a-1	Director	MD NA			Baltir		p Code				IOo Citizer	n of What Coun	to/2
	with t		10e. Street and Number				101. 21					rog. Citizer		uy:
	eath	erai	314 N. Mount Street	12 Was Dec	edent Ever in U	IS 13 1	Was Dece	21223		nin? (Spe	cify Yes or No-	14.	USA Race - Americ	an Indian.
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or iteme 23e or 28e-f show other traumatic event, the Modical Examiner must be milliad at	by Funeral	11. Marital Status  1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Fo	orces? 2 📉 No ive			ecify Cubar			Rican, etc.)		Black, White, becify: Bla	etc.
Ş	tura	edt	15. Decedent's			16a. Dece	dent's Usu	ual Occupa	ition			16b. Kind	of Business/Inc	
Maryland 21215-0036	within 72 ane. than "na ne M. cilis	Completed	(Specify only highest g Elementary/Secondary (0-12) 10	rade completed)	1-4or 5+)	life.	kind of wi DO NOT ( Domest:	ork done d use retired)	uring most	t of workii	ng		Homes	
d 2	Hygir Hygir other	ပိ	17. Father's Name (First, Middle, La	st)			AMESE		18. Mothe	r's Name	(First, Middle,	Maiden Su	mame)	·
lan	Aental rked o	To Be	Ollie Louden						Lilli	an Lo	uden			
lary	12 should be and Mental 7 is marked of raumatic ever		19a. Informant's Name/Relationship	(Type, Print)			•	,			l Route Numbe		own, State, Zip	Code)
	is 1 and 2 of Health a litem 27 is other trau		Teresa Louden/Siste	r	20h I	314 N.			et Bal		e, MD 212		ion - City or To	um State
Baltimore,	Mof Fi		20a. Method of Disposition 1 🖾 Burial 2 ☐ Cremation 3		State	cemetery, crei	natory or	other place	1				more, MD	WII, State
Ħ.	nit. Parantinon ortant: injury		'4 □Donation 5 □ Other (Special Signature of Funeral Service Lice		Arb	utus Mem		Park	-	1-25-	05	Daili	more, no	
Ba	permit. Pages 1 an Department of Heal Important: if Item 2 any injury or othar once.		21. Signature of Pulleta-Optivice Lice	3	•					•	638 N Ci	lmor S	t Polto	MD 21217
	Physician /Medical Examiner	16	23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	a. $\frac{RESI}{Due to}$	each line. PLANGUM  (or as a consec	FALUEL quence of):		de of dying	, such as	cardiac o	r respiratory and	est,		Approximate Interval Between Onset and Death
68760,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burtal-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to	(or as a consec	quence of):								
P.O. Box	that the death certific ed by the attending p detached for use as I	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 Live	utcome of pregn birth 2  Feta nant at time of a nown	al death 3	Ectopic p Other (s	pecify)				230	I. Date of delive Month	ry Day Year
	quires tha n signed uld be del	ρ	Part II. Other significant conditions  DEM TATIM	contributing to c	death but not res	sulting in the u	nderlying	cause give	n in Part I.					e cause of death? ably 4 ØUnknown
of Vital Records,	9 4 9	Completed	AMIAL FIBRILLAMI	oN							24a. Was a autop perfor	sv	!4b. Were autop prior to con death? 1 \( \subseteq \text{Yes}	osy findings available npletion of cause of
tal	ician: Th certificate ector, pag	Be C	25. Was case referred to medical						26. Place	of Death	(Check only or		1 1 1 1 0 3	20,140
<u> </u>	· · =	0	examiner? 1 ☐ Yes 2 Ø No	Hospital:	Inpatient 2	ER/Outpatier	nt 3 D	OA Othe	r		ne 5 Resid		Other (Specify	')
	ding h. After fune	tion: T	27. Manner of Death  1 Natural 5 Pending 2 Accident investigat		of Injury oth, Day Year)	28b. Time o Injury	f M	28c. injury Work 1 🗆 Y	at ? /es 2.21		28d. Describe h	ow injury o	ccurred	
Division	Dir te	Certification:	3 Suicide 6 Could not determine	200. Flat	e of Injury - At h fing, etc. (Speci	iome, farm, str fy)	reet, facto	ry, office		1	28f. Location (S City or Tow		lumber or Rura	l Route Number,
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical (		Physician: To the taminer: On the tand man										
	To the To the Comp	Me	29b. Signature and title of certifier					c. License			1	9d. Date s	igned (Month, i	Day, Year)
)			by no				A	N 417	6435	F1660	2 1	evenbe	17,200	25
			30. Name and address of person where Beverley FANG		se of death (Ite		Print)	no	21230	)				
	Sta Regist		31. Date filed (Month, Day, Year)	82.1	Registrar's Sign	ature Appe	W.							

			1 - For State Registrar		epartment of Health and	d Mental Hygie	711115	37618
ľ	Physici		Decedent's Name (First, Middle, Last)	elain		2. Date of Death	Day 18 14 2005	3. Time of Death 7:05 PM
	/Medic Examin Funeral		4a. Facility Name (If not institution, give stre Howard County) 5. Social Security Number 6. Sex	et and number) General Hospi 7. Age (In yrs. last birt)	Months Days Hours M	eath / A	4c. County of Deeth  1+0 W ar)  9. Birthp Cour	ARD place (State or Foreign
	Director		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town	or Location	JUNE 8; 1		Od. Inside City Limits
	death with the Maryland ms 23a or 28a-f show court be notified at	Director	MARYLAND HowA	HRD	Co Lums		Citizen of What Cour	1 ☐ Yes 2, No
	sath with		6192 GREENS	BLADE GARTH Was Decedent Ever in U.S.	1 210	45	14. Race - America	A
20	or Ite	by Funeral	11. Marital Status  1 Never Married 2 Married  3 🗷 Widowed 4 Divorced	Armed Forces?  1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu 1 ☐ Yes 2 X, No Specify:	erto Rican, etc.)	Black, White,	
70-617	ithin 72 hours ne. "natural", e Medical Ex	Completed	15. Decedent's Educati (Specify only highest grade co	on 16a. College (1-4or 5+)	Decedent's Usual Occupation (Give kind of work done during most of vide. DO NOT use retired)	warking	Kind of Business/Inc	dustry
Jana Zi	uld be filed w Aental Hygier rkad othar th tic evant, th	To Be Cor	(INKNO:UN)  17. Father's Name (First, Middle, Last) (	UNKNOWN)	TEL + RESTAURANT C 18. Mother's N	Name (First, Middle, Maid		
ore, mary	ges 1 and 2 shou t of Health and N If itam 27 Is ma or other traumal		19a. Informant's Name/Relationship (Type,  LINDA PERRY  20a. Method of Disposition  1 ■ Burial 2 □ Cremation 3 □ Rem	SRAND DAUGHTED  20b. Place of cemetery	Mailing Address (Street and Number or REE N BL) Disposition (Name of crematory or other place)	Date GARTH	CoLumbia Location - City or To	MD. 21045 own, State
Daltim	permit. Pag Department Important: any injury once.		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee	1/ Williams	22. Name and Address of Ricility	BROWN JI	P. FUNER	PAL HOME
	Physician		23a. Part1. Enter the disease, or complicat shock, or heart failure. List only one of Immediate Cause (Final disease or condition a	ause on each line.	ot enter the mode of dying, such as card			Approximate Interval Between Onset and Death
	/Medical Examiner	<u>.</u>		Due to (or as a consequence of	ere anemia			
8/60,	cate be executed physician and the burial-transit	ai Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	//	unoned			
X 08/	tifi as	음	d	If yes, outcome of pregnancy				
O. Box	0 0 0	hysician/Me	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 Ectopic pregnancy 5 Other (specify)		23d. Date of delive Month	Day Year
cords, P.	sign sign d be	by P	Part II. Other significant conditions contrib	outing to death but not resulting in	the underlying cause given in Part I,		o use cantribute to th	ne cause of death?
Hec	The law ate has b page 2 sl	Completed				24a. Was an autopsy performed 1 Yes 2	prior to cor	psy findings available inpletion of cause of
or vital	d is	To Be	25. Was case referred to medical examiner?  1 □ Yes 2 No	pital: 1 ☐ Inpatient 2 ➤ ER/Out	Othor	Death (Check only one)  J Home 5 Residence	6 Other (Specify	()
UNISION O	To tha Hospital or Attending Ph within 24 hours after death. To tha Funaral Diractor: After th completely filled in by the funeral	ertification;	Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year) 28b. Ti	me of 28c. Injury at Work?  M 1 Yes 2 No	28d. Describe how in	jury occurred	
Ž	ital or Att urs after d ral Diract lled in by 1	0	4 Homicide determined	28e. Place of Injury - At home, far building, etc. (Specify)		28f. Location (Street City or Town, Sta	afe)	
	To tha Hospital or Attending within 24 hours after death. To tha Funaral Diractor: After completely filled in by the funer	Medical	(Check only 2 Medical Exeminer one)	an: To the best of my knowledge, On the basis of examination and and manner stated.	death occurred at the time, date and pla /or investigation, in my opinion, death oc	curred at the time, date a	ind place, and due to	the cause(s)
	To To		29b. Signature and title of certifier	M	29c. License number  57870	N 6	Date signed (Month, I	19TH 2005
	1		30. Name and address of person who comp  Surcen Ando	leted cause of death (Item 23a) (1	21 KON- 10 -10 1	Clarksuill	i MD 3	21029
•	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signature	free			

			State     Registrar  1. Decedent's Name (First, Middle, Last		Cei	tificate of	Death	Tental Hygie Reg.	No.	כוס
	Physici /Medic		Richard Kevir	Marin,	SR.			Month November	Day Year 21, 2005 3	:00 pm <sup>M</sup>
	Examin Funeral Director	er	217 02 0220	[	last birthday) Yrs.	ESSEX If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye March 19,	Baltimore 9. Birthplace (Country) 1954 Marylan	State or Foreign
the Maryland	items 23a or 28e-f show	Director	Usual Residence of Decedent           10a. State         10b. County           Maryland         Baltimor           10e. Street and Number		y, Town or Lo	cation		10g.		side City Limits ☐Yes 2X No
5-0036 72 hours after death with the Maryland	al', or items 23a o Evandour must be	by Funeral	122 Riverside Road  11. Marital Status  1  Never Married 2 Married 3 Widowed 4 Optivorced	12. Was Decedent Ever in U Armed Forces? 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates:	ł	21221 Was Decedent of F f Yes, specify Cub	dispanic Origin? (Spi an, Mexican, Puerto Specify:		S. A.  14. Race - American Ind Black, White, etc.  Specify: White	ian,
1215-0 within 72 ho	iene. r than "natural", or the Medical Exami	Completed	15. Decedent's Education (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	16a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retire	pation during most of works d)	ing 168	b. Kind of Business/Industry	
ind 2	ntal Hyg nd othe event,	Be	12 17. Father's Name (First, Middle, Last) Andre Marin		Polic	e Office:	T	e (First, Middle, Mai	aw Enforcement den Sumame)	t
	h and 7 le m treum	70	19a. Informant's Name/Relationship (T) Jeffrey Allen Mari				and Number or Rura	al Route Number, C	ity or Town, State, Zip Code) Iaryland 21221	
<b>(1)</b>	nent of Healt int: If item 2 iry or other		20a. Method of Disposition  1 XBurial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Ismaval from State	emetery, crer	sition (Name of natory or other pla L Mem. Ga	ce)		Location - City or Town, Staltimore, Mary	
Balti permit.	Department of H Important: If ite any Injury or ot once.		21. Signature of Funeral Service Licens	Pouske			ki Funeral Eastern Av		sex, Maryland	21221
1	nysicien and Medical kaminer ite prusitivasii	ical Examiner	23a. Part. Enter the disease, or compinshock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ne cause on each line.	uence of):				Approximation of the state of t	oximate all Between t and Death
	ied by the attending photographic detached for use as to	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	Ideath 3	Ectopic pregnancy	у		23d. Date of delivery Month Day	Year
ords, P.O.	been signed by should be deta	Ď	Part II. Other significant conditions co.	ntributing to death but not res	ulting in the u	nderlying cause giv	ven in Part I.	23e. Did tobac 1 ☐ Yes	co use contribute to the caus	
Rec	ste has page 2	e Completed	25. Was case referred to medical					24a. Was an autopsy performed	24b. Were autopsy fin prior to completio death? No 1 \( \text{Yes} \) 2 \( \text{N} \)	n of cause of
of Vita Physicien:	is certific director,	To B	examiner?	lospital: 1   Inpatient 2	ER/Outpatien	t 3 DOA Ott		n (Check only one)	e 6 Other (Specify)	
Vision of Attending Phy	After fune	Certification: T	27. Manner of Death  1. Natural 5 Pending investigation  2 Accident investigation  3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. injui Wor		28d. Describe how i		
DIVI	urs after death ral Director: lled in by the		4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	y)			City or Town, S		e Number,
To the Hosp	within 24 hours a To the Funeral C completely filled i	Medical	(Check only 2   Medical Exami	sician: To the best of my kno ner: On the basis of examina and manner stated.	tion and/or in	restigation, in my o	ppinion, death occurr	ed at the time, date	and place, and due to the ca	use(s)
<sup>2</sup>	To Cor		290. Signature and title of certifier	V- M-fang	MD	Do.	57061	29d.	11/22/0 5	ear)
Lat.	Sta	te	29b. Signature and fille of certifier  30. Name and address of person who come address of person who come and address of person who come and address of person who come and address of person who come and address of person who come and address of person who come and address of person who come and address of person who come and address of person who come a person who come and address of person who come address of person who come address of person who come address of person who come address of person who come address of person who come address of person who come address of person who come address of person who come address of person who come address of person who come address of person who come address of person who come address of person who come address of person who come address of person who come address of person who come address of person who come addres	empleted cause of death (Item RANA, M.) Registrar's Signa	123a) (Type, 4920- Iture	CAMPB.	ELL BLO	D, BAC	Timore, MI)	21236

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** November 13, Gloria B. Mitesser 2005 8:30 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Village Care and Rehab. Montgomery Village Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours 1 □ M 2 1 F 77 Director Vrs December 20, 1927Pennsylvania 197-20-7937 Usual Residence of Decedent the Maryland 10a State 10h Count 10c. City, Town or Location 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event. It s Medical Examiner must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2X No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11212 Schuylkill Road 20852 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. illed within 72 hours after 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☒ No þ 3 N Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) d 2 should be filed within ; th and Mental Hygiene. 7 is marked other than "r Government Elementary/Secondary (0-12) College (1-4or 5+) Office Manager Subcontractor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pasqual Fantauzzi Lucy D'Aprile 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: if item 27 is any injury or other trau Ellen Buchegger / Niece 17 Meadowcroft Court, Montgomery Village, MD 20886 20a. Method of Disposition 20b. Place of Disposition (Name of November 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Montgomery Crematorium, Inc. \* 4 ☐ Donation 5 ☐ Other (Specify) 14, 2005 Bethesda, Maryland 22. Name and Address of Facility Rohert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 21. Signatur Lo Furerai Service Licensee M01356 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Congestive Heart Failure disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner be executed burial-transit Due to (or as a consequence of): physician the burial Box 68760. Physician/Medical The law requires that the death certificate IF FEMALE esr 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? for Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. the detached ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 Yes 2 No 3 Probably 4 ☐Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed? 1 Yes Division of Vital 1 Yes 2X No 2□ No the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 X Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2K No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 5 Pending 1 X Natural s after deau. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital Committee To the Funeral Directory 1X Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) H00051280 November 14, 2005 30. Name and address of person who completed cause of death (Item 3a) (Type, Print) 9715 Medical Center Drive #201, Rockville, Maryland 20850 Anushiravan Dadgar, D.O. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 2 2 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Veel **Physician** 15, 2005 8:39 PM M November Kunigunda Kaup McGurty /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 8021 Park Lane Bethesda If Under 24 Hrs. Montgomery If Under 1 Year 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months 1 □ M 2 🗓 F Vrs 95 Director 577-03-3974 November 19, 1909 Nebraska Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show event, the Medical Examiner must be nutified at 1 ☐ Yes 2 No Director Maryland Bethesda Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō or Items 23a 20814 United States Funeral 8021 Park Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11 Marital Status filed within 72 hours after Hygiene. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: à Specify: 3 X Widowed 4 Divorced "natural", White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry rthan Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygien Important: If item 27 Is marked other th, any injury or other traumatic event, Ite, once. Transporation Manager Law Firm 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Christina Goebel John Kaup 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8021 Park Lane Bethesda, Maryland 20814 <u> Alice C. McGurty/ Daughter</u> 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Aven Cemetery 18, 2005 Silver Spring, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) of Heaven Cemetery Silver Spring, Maryland 21. Signature of Fineral Service Licensee M00335 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Physician Congestive Heart Failure /Medical resulting in death) Due to (or as a consequence of): **Examiner** Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Completed by Physician/Medical as the IF FEMALE: nse 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy in the past 12 months? for Month Day Year 5 Other (specify) detached i 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? pe 3 Probably 4 □Unknown 1 ☐ Yes 2 X No been 24b. Were autopsy findings available prior to completion of cause of death? has page 2 autopsy performed? this certificate 2 🗆 No 1 Yes 2 No 1 Yes or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 0 2X No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred : After t Certification: 5 Pending investigation 1 X Natural М 1 ☐ Yes 2 ☐ No after death. 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal 29a. Certifier Medi To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature title of certifier 2 November 16, 2005 D0060167 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5530 Wisconsin Avenue #930 Chevy Chase, Maryland 20815-4316 M.D.Michael Solomon, Ν. State

DHMH 17 Rev 1/2001

Registrar

	State of Maryland / Departr  1 - State Amend Items#20b&20c per FH G849eHH  1. Decedent's Name (First, Middle, Last)	Cate of Seath	Reg. N	
Physician	Robert Alvin McCain		Month D	Day Year 3. Time of Death
/Medical		City, Town, or Location of Death		13, 2005 10:46 p.™
Examiner	Bon Secours Hospital	Baltimore		1/a
uneral		Under 1 Year   If Under 24 Hrs.	8. Date of Birth (Month, Day, Yea	
rector	219-20-8906	onths Days Hours Min.	May 15, 1	
	Usual Residence of Decedent			-
H L	10a. State 10b. County 10c. City, Town or Location	'n		10d. Inside City Limits
Le nutitied at Director	Maryland n/a Baltimore			1√2 Yes 2 □ No
		Of. Zip Code	10g. C	Citizen of What Country?
varmut	512 S. Payson Street	21223		ited States
by Funeral	1 X Never Married 2  Married	Decedent of Hispanic Origin? (Sp., specify Cuban, Mexican, Puerto es 2XI No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
Completed	15. Decedent's Education 16a. Decedent's	Usual Occupation	16b.	Kind of Business/Industry
ple	(Specify only highest grade completed) (Give kind life. DO N	of work done during most of work IOT use retired)	ing	
5		y quard		building
Be (	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, Maide	
Į.	Larkins McCain	Sophia	Louise Gua	ntmyer
		Idress (Street and Number or Rura	al Route Number, City	or Town, State, Zip Code)
	Robert Horn - friend 2003 Eac	le Street, Balt	imore, Mar	yland 21223
any injury or other traumatic event, the Medical Evant set must snce.  To Be Completed by Funeral	20a. Method of Disposition  XXBurial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)	-		Location City or Town State OS MILLS, MD Ltimore, Maryland
any inj		ne and Address of Facility Hub	bard Funer	
s the burial-transit using using a land and a land and a land and a land	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a	ortic Ana	wysw	Interval Between Onset and Death
edical Examin	Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):			
Physician/Me		pic pregnancy er (specify)		23d. Date of delivery  Month Day Year
by P	Part II. Other significant conditions contributing to death but not resulting in the underly	ring cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
ed			1 ☐ Yes 2	2 No 3 Probably 4 Onknown
Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No
Be	25. Was case referred to medical examiner?  1 M yes 2 No. Hospital:	26. Place of Death		
2	1 Inpatient 2 LAEH/Outpatient 3		ne 5 Residence	
Certification:	1) Sentural 5 Pending (Month, Day Year) Injury 2 Accident investigation 3 Suicide 6 Could not be	Work? 1 Yes 2 No	28d. Describe how inju	ury occurred  Ind Number or Rural Route Number,
	building, etc. (Specify)		City or Town, Stat	(9)
Medical Certif	29a. Certifier (Crock only one)  Crock only one)  Crock only one)  1 Certifying Physician: To the best of my knowledge, death occurrence of examination and/or investig and manner stated.	arred at the time, date and place, a ation, in my opinion, death occurre	and due to the cause(s ad at the time, date an	s) and manner as stated.  Individual place, and due to the cause(s)
Med	29b. Signature and the objectifier	29c. License number OCME		ate signed (Month, Day, Year) 7ember 14, 2005
1	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	111 Penn Stree	t Baltimo	ore, Maryland 21201
	31. Date filed (Month, Day, Year)  NOV 2, 2, 2005			

			1 - State of Maryland / Dep	artment of Health and Martificate of Death	-	giene 2.005	37623
	Physici	an	1. Decedent's Name (First, Middle, Last)  Mulis		2. Date of Dea Month	Day Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	11 - 20	4c. County of Death	3:45 PM
	Examin	ier	1605 N. ROSEDALE STREET	BALTIMORE		NA	
	Funeral Director		5. Social Security Number 6. Sex 180 M 2 F 7. Age (In yrs. last birthday 4 Yrs.	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth (Month, Day 02. 19. (	9. Birth Q3Q	pplace (State or Foreign untry SC
	land ow		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
	a-f sh	ctor	MD NA BALTIMOR	٤			1 X Yes 2 □ No
	or 28	Funeral Director	10e. Street and Number	10f. Zip Code	1	10g. Citizen of What Co	untry?
1	eath v	eral	1605 N. ROSEDALE STREET  11. Marital Status 12. Was Decedent Ever in U.S. 13.	21216 Was Decedent of Hispanic Origin? (Sp	ecify Yes or No-	USA 14. Race - Amer	ican Indian,
9	after d		Armed Forces? 1 □ Never Married 2024 Married 1 □ Yes 2 12 No	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White	o, etc.
003	72 hours after death with the Maryland natural', or items 23s or 28s-1 show diesi Examiner must be notified at	d by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:				ACK
15	in 72 in 72 in 72 in 72 in 72 in at	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	ring	16b. Kind of Business/I	ndustry
212	e filed within al Hygiene. other then "	Comp	PAIN  Elementary/Secondary (0-12)  Grand NA  PAIN	KER		SELF EMP	LOYED
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. Item 27 is marked other than "netural", or items 23e or 28e-1 show other traumatic evant. The Medical Exertirer must be notified at	Be	17. Father's Name (First, Middle, Last)	18. Mother's Nam			
Z	2 should be and Mental is marked o	2	JOHN ALEN MILES  19a. Informant's Name/Relationship (Type, Print)  19b. Mail	ANNIE N			ip Code)
	alth ar 27 is ar trau					MD 21216	
ore,	iges 1 and of Head it of Head it it itam or other		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 20b. Place of Disposition cemetery, cre	osition (Name of matory or other place)	Date	20c. Location - City or 1	Town, State
Baltimore,	Pag tment tant: I		`4 □Donation 5 □Other (Specify) GREENMOL			BALTIMORE,	MD
Ba	permit. Pages 1 Department of H Important: If its any injury or ot once.		Vaughn 1	2. Name and Address of Facility AUGHN C. GREENE FUN 151 BALTO. NATL' PIKE ,	BALTO. N	ND 21229	
I,			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.		or respiratory arr	est,	Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):	concer			
	Examiner						
	ν ÷	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying				
	xecute and Il-trans	Examine	Cause (Disease of Injury that initiated events c.  C.  Due to (or as a consequence of);				
8760,	sate be executed by sician and the burial-transit		d				
9	ntificat ng phy s as th	Medi	IF FEMALE:				
Вох	death certificate be executed e attending physician and nd for use as the burial-transii	Physiclan/Medical	23b. Was decedent pregnant in the past 12 months?	Ectopic pregnancy Other (specify)		23d. Date of deliv Month	very Day Year
P.O.	that the de ed by the detached	nysic	1 Yes 2 No 9 Unknown 9 Unknown	Other (specify)	Cope.		
Vital Records, P	w requires that the been signed by th should be detache	þ	Part II. Other significant conditions contributing to death but not resulting in the to the significant conditions contributing to death but not resulting in the to the significant conditions.	inderlying cause given in Part I.		bacco use contribute to es 2 □ No 3 □ Pro	
eco	aw as b	Completed	,, &		24a. Was a	n 24b. Were aut	opsy findings available ompletion of cause of
Ä	The ate h page	Com			perforr	med? death? 2☑No 1☐Yes	2 No
Vita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	26. Place of Deat	-		
	p Phys er this eral di	n: To	1	f 28c. Injury at		ence 6 Other (Spec ow injury occurred	ify)
ion	Attanding It death, ector: After by the funer	atlo	1 ☑Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No			
Division of	or At fter of Jirech in by	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (St City or Town	treet and Number or Rui n, State)	ral Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, dea 2 Medicel Exeminer: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place, vestigation, in my opinion, death occur	and due to the cared at the time, di	ause(s) and manner as ate and place, and due	stated. to the cause(s)
	To the within To the comp	2	29b. Signature and title of certifier	29c. License number	2	9d. Date signed (Month	Day, Year)
•	4		· aur co	D-0035674	5	swenger 2	1,2005
5			30. Name and address of person who completed cause of death (Item 23a) (Type Whether Should Clements 31. Date filed (Month, Day, Year) 32. Registrar's Signature	Print) 1900 E. NEVIL	Me >	1239	207
	Sta Registr	te	31. Date filed (Month, Day, Year)  NOV 2 2 2005  32. Registrar's Signature	boule			

Christopher Miou Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 05-07600 JM State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month Year **Physician** Christopher Miou 2005 0833 November /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Route 301 near Strawberry Lane Ceci1 Warwick Hours Min. 8. Date of Birth (Month, Day, Year) Sept. 13,1964 If Under 1 Year Months Days 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 1 **X**M 2 □ F China 071-74-9886 41 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County **ehow** the Medical Examiner must be notified at 1 Ty Yes 2 □ No Flushing New York Queens Funeral Director 28a-f 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ò 238 132-61 Sanford Avenue Apt. 2G United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 5 1 ☐ Yes 2 🕱 No Specify: Specify: Chinese Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind ot Business/Industry 15. Decedent's Education (Specify only highest grade completed) Delivery College (1-4or 5+) Elementary/Secondary (0-12) Trucking Owner 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any linjuy or other traumatic event 2018. Li Hsiu Wen Sze Tan Miou 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 132-61 Sanford Avenue, Apt. 2G, Flushing, NY 11355 Yu Hui Huang, Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) \*\* Flushing Cemetery 11/19/05 Flushing, New York 21. Signifure of Fune Al Service Leensee 22. Name and Address of Facility Chun Fouk Funeral Service, LLC MIT 134-35 Northern Blvd. Flushing, NY 11355 M01113 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Muthal Vapores

Due to (or ds a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of Examine attending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Day Year Month ate has been signed by the atte page 2 should be detached for 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۵ 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 1 Yes 2 No 1 □(Yes 2 □ No s effer deau... ral Director: Affer this cer... 26. Place of Death | Check only one) To Be 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Cther: 4 Nursing Home 5 Residence 6 Other (Specify) Scene 1X Yes 2 □ No 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Certification: Injury or Attending 1 Natural 5 Pending truck driver us collision 2 No 8:10 investigation Nov 10, 2005 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State), Street berry Lanes Rt 301 crest of Street berry Lanes 6 Could not be determined within 24 hours efter der To the Funeral Directo completely filled in by th 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide street (Down To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie

DHMH 17 Rev 1/200

State Registrar 31. Date tiled (Month, Day, Year)

Tasha Zuveenberg 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MA

111 Penn Street Baltimore, Maryland 21201

OCME

November, 11, 2005

			For State Registrar		State of	Marylan		artment of			ental Hy	giene	) 5	37625
	. 36		Decedent's Name (First, Middle)	fle, Last)							2. Date of De	ath		3. Time of Death
7	Physicia		Bernard V	11111:	m Min	shall.	Jr.			1	Month	Day	Year	01:35 AM
	/Medic Examin		4a. Facility Name (If not instituti					4b. City, Town	, or Location of	of Death		4c. Count		
4.5		44	Sacred L	lear	I HO	OSPITE	+L	Cin	nberi	auT		Alle	2GCV	14
ж.	Funeral	-	5. Social Security Number	6. Sex		. Age (In yrs.		If Under 1 Year Months Day		24 Hrs. 8 Min.	3. Date of Bit (Month, Da	nth ay, Year)	9. Birth	place (State or Foreign intry)
	Director		234-26-9678	1 1 1 2 1	/ 2□F	83	Yrs.					6,1922		oole, MD
	pur *		Usual Residence of Decedent  10a. State 10b. Coun	v		10c. Cit	ty, Town or Lo	cation						10d. Inside City Limits
	anyla eho	ក	The state of the s	nera]	ı		Keys							1 X Yes 2 □ No
	28a-1	Director	10e. Street and Number	.пста.			Reya	10f. Zip Code				10g. Citizen of	What Cou	intry?
	with a or		585 Chesti	11+ C1	reet			267					SA	,
	72 hours after death with the Maryland natural; or iteme 23e or 28e-f ehow sical Examirae must be natified at	Funerai	11. Marital Status		. Was Dece	dent Ever in U	.S. 13.	Was Decedent o	of Hispanic Ori	igin? (Speci	rfy Yes or No	o- 14. Ra	ce - Amer	ican Indian,
10	riter	Fun	1 ☐ Never Married 2 M Ma	rried	Armed Ford	2 🗆 No		f Yes, specify C			ican, etc.)		ck, White	, etc.
93	urs a	þ	3 ☐ Widowed 4 ☐ Divorce	d	If Yes, Give Year or Da	tes: WW ]	II.	1⊡Yes 2 <b>X</b> N	lo Specify:			Speci		ite
21215-0036	natur	Completed	15. Decede (Specify only high				16a. Dece	dent's Usual Occ	cupation	at of working	7	16b. Kind of E	Business/Ir	ndustry
2	도 교육	npie	Elementary/Secondary (0-12)		College (1-	4or 5+)	life.	DO NOT use ret	ired)					
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nd	d ia b	Be	17. Father's Name (First, Middle									, Maiden Suma		
Maryland	should be nd Mental marked o	은	Bernard Wi			hall, S						idenwalt		
Jar	~ 4 = 4	- 37	19a. Informant's Name/Relation			c	1					er, City or Town		
	1 and 1 and 1 and 2 and		Virginia M. Mi 20a. Method of Disposition	nsna.	LT/ MT			S5 Chest sition (Name of	-	reet		20c. Location	26720 - City or T	
ō	it of h		1 XBurial 2 Cremation		moval from S	state	cemetery, crei	natory or other p	olace)	Nov.		200. 200211011	Oity of 1	51111, 51a.to
altimore,	permit. Pages Department of h Important: if its eny injury or of		4 Donation 5 Other		1	E		r Cemet		2005		Romn		
Bal	Deparement of the period of th		21. Signature of Euneral Service	e Licensee	Aui	TIL		P. Name and Add				Funeral		e
	20200		23a. Part1. Enter the disease,	6726	Approximate									
			shock, or heart failure. Li	st only one	cause on ea	ich line.								Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	_ a.	CO N	GEST	TUE	CARD	2	FA	1441	SE		( WEEK
198	/Medical Examiner			1	Due to (d	or as a consec	quence of):	0 A 10 P			01 -			E ARRAITME
		er	Sequentially list conditions, if any, leading to immediate	b.	Due to (c	or as a consec	L (C)	LKKV	2 (U V	yo	13-47	+4		3 191010 (115
V	ted nsit	nin	cause. Enter Underlying Cause (Disease or injury	≺			,,.							
	be executed siction and burial-transit	Examin	that initiated events resulting in death) Last	C.	Due to (d	or as a consec	quence of):							
8760	death certificate be executed e attending physicien and ad for use as the burial-transit													
687	ficate physics the t	Physician/Medical		Q.										
ŏ	eath certific attending p for use as	Z	IF FEMALE: 23b. Was decedent pregnant	23		ome of pregn						23d. Da	ale of deliv	very
B	death s atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No		4□Pregna	nth 2 ☐ Feta ant at time of c		]Ectopic pregna ] Other (s <i>pecify</i> )				M	onth	Day Year
0		hys	9 ☐ Unknown		9 Unkno	wn								
Э,	The law requires that the ite hes been signed by th bage 2 should be detache	by P	Part II. Other significant cond	tions cont	nbuting to de	ath but not res	sulting in the u	nderlying cause	given in Part I	l.	23e. Did	tobacco use cor	tribute to	the cause of death?
rd	w require been sig should b										1 🗆	Yes 2	3 Pro	bably 4 □Unknown
Records,	law re ss bee 2 sho	piet									24a. Was		Were aut	opsy findings available ompletion of cause of
Re	The is ate he	Completed									auto perf	ormed?	death?	2 □ No
Vital		0	25. Was case referred to medi	al					26. Place	e of Death (	Check only			
>	ysic Is ce direc	To B	examiner?	Ho	spital:	patient 2	ER/Outpatie	nt 3 DOA	Other: 4 🗆 Nu	ursing Hom	e 5 □ Res	idence 6 □Ot	her (Spec	ıfy)
Jοι			27. Manner of Death 1 ☐ Patural 5 ☐ Pen	tion	28a. Date o	f Injury n, Day Year)	28b. Time o	f 28c. Ir	njury at Work?	28	d. Describe	how injury occu	rred	
<u>Ö</u>	Attending it death.	atic	2 Accident inve	stigation	,				☐ Yes 2 ☐	No				
Division	or Attendate death of Director:	Certification;	3 ☐ Suicide 6 ☐ Cou 4 ☐ Hornicide dete	d not be mined	28e. Place buildin	of Injury - At h	iome, farm, st	reet, factory, offic	ce	28		(Street and Num wn, State)	ber or Rui	ral Route Number,
	rs after al Dir	Cer												
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	edical	(Check only 2' Medic	ing Physi al Examin	er: On the ba	sis of examina	owledge, deat ation and/or in	h occurred at the	e time, date an	nd place, an	nd due to the	cause(s) and m	anner as	stated. to the cause(s)
	the thin 24 the f	Medi	one)		and mann	er stated.								
	Vit To Con	-	29b. Signature and title of certi	1	4	ノ	00.0		ense number	00		29d. Date sign	Mont)	Jay, rear)
			, UM	var	- W	m	(N)	100	-> 4	0,6		MOVE	4 176	14 11, 2005
	10		30. Name and address of personal PR, William	am	mpleted cause	of death (Item	m 23a) (Type,	Print) 21 ve C	nwper	rain	>, NC	D ars	02	TR 11, 2005
1000	Sta Registi		31. Date filed (Month, Day, Ye. NOV 2 2	2005	82. Re	egistrar's Sign	ature	W						

			FOR	rtment of Health and Mental H	lygiene Reg. No. 005 37626
被	Physicia		Decedent's Name (First, Middle, Last)     Alice Elizabeth Murphy	2. Date of Month	
	/Medic Examin		4a. Facility Name (If not institution, give street and number) Union Memorial Hospital	4b. City, Town, or Location of Death Baltimore	4c. County of Death N/A
	Funeral Director	90	5. Social Security Number 6. Sex 7. Age ( <i>In yrs. last birthday</i> ) 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	If Under 1 Year	Day, Year) Country)
	Aaryland I ehow	ō	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Loc  Maryland N/A Baltimo		10d. Inside City Limits 1 ☑ Yes 2 □ No
	with the Page or 28a-	Direct	10e. Street and Number 2819 Hampden Avenue	10f. Zip Code 21211	10g. Citizen of What Country? USA
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatih and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examination and item and pance.	Completed by Funeral Director	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Widowed 4 Divorced 1 Yes or Dates:	I Jas Decedent of Hispanic Origin? (Specify Yes or Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ Yes 2 ☑ No Specify:	
Maryland 21215-0036	d within 72 hoi giene. rr than "natura tha Medical I	ompleted	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  11  16a. Deced. (Give k //ife. D  Homel	ent's Usual Occupation cind of work done during most of working O NOT use retired) maker	16b. Kind of Business/Industry Own Home
land	uld be file Aental Hyg rked othe	To Be C	17. Father's Name (First, Middle, Last) Fred P. Hepding, Sr.	18. Mother's Name (First, Mid Anna Mae	
	alth and A		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing	g Address <i>(Street and Number or Rural Route Nu</i> Hampden Avenue Baltin	mber, City or Town, State, Zip Code) nore, Maryland 21211
Baltimore,	Pages 1 and nent of He nent of Item ant: If item arry or other			of tition (Name of alony or other place)  Veterans Cem. 11/23/200	20c. Location - City or Town, State D5 Garrison Forest, MD
Balt	permit. Departr Importa any inji		21. Signature of Funeral Service Licensee 22.	Name and Address of Facility Burgee-Henss-Seitz Fune 3631 Falls Road, Baltin	eral Home, Inc. 21211 Hore, Maryland
	Physician		23a. Part1. En life the disease, or complications that caused the death. Do not ente shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition	or the mode of dying, such as cardiac or respirator	y arrest, Approximate Interval Between Onset and Death
8760, 4	Medical Examiner  ohysician and the burial-transit	dicai Examiner	d		
.O. Box 68	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes   2   No   9   Unknown   23c. If yes, outcome of pregnancy   1   Live birth   2   Fetal death   3   4   Pregnant at time of death   5   9   Unknown   5	Ectopic pregnancy Other (specify)	23d. Date of delivery Month Day Year
<u>α</u>	quires that in signed b uld be deta	ρ	Part II. Other significant containers continuously to death out not resulting in the un		id tobacco use contribute to the cause of death? ☐ Yes 2 ☐ No 3 Probably 4 ☐Unknown
Division of Vital Records,		e Completed	25. Was case referred to medical	1 \( \text{Ye}	utopsy prior to completion of cause of death? s 2NNo 1 Yes 2 No
of Vit	Physician: r this certificatal director,	To B	examiner? 1   Yes   2   No   Hospital: 1   Inpatient   2   ER/Outpatient		
ivision	r Attending Physician: er death. rector: After this certifica by the funeral director, i	Certification:	1 Natural 5 Pending (Month, Day Year) Injury 2 Accident Investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, stree building, etc. (Specify)	Work?  M 1 ☐ Yes 2 ☐ No  set, factory, office 28f. Locatio	n (Street and Number or Rural Route Number, Town, State)
۵	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical Cer	29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death	occurred at the time, date and place, and due to to estigation, in my opinion, death occurred at the time.	the cause(s) and manner as stated.  ne, date and place, and due to the cause(s)
_	To the within 2 To the complet	Med	29b. Signature and title of certified	29c. License number	29d. Date signed (Month, Day, Year)
	7		30. Name and address of person who completed cause of death (Item 23a) (Type, F	Print) 127/0/40	Ind MN
	Sta Registi		31. Date filed (Month, Day, Year)  NOV 2 2 2005  32 Registrar's Signature	estigation, in my opinion, death occurred at the tin  29c. License number  AT 24389 46  Print)  The Memorial Hospi	10000
Also			NUV & N LOOD		

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State of Maryland / Department of Health and Mental Hygiene or

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· g. 140.							

Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician November 15, 2005 11:00 p.<sup>™</sup> Robert A. Moore /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 105 - 2nd Street (upstairs) Prince George's Laurel 8. Date of Birth (Month, Day Ye Dec. 10, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Year) 1947 Days Months Hours 1XM 2□F 57 Virginia Yrs. 216-44-5705 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or itema 23a or 28a-f ahow traumatic ayant, the Medical Examinar must be notified at 1 ☐ Yes 🏋 No Prince George's Laurel Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 105 2nd Street 20723 United States filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S.
Aggred Forces?

12 Yes 2 \( \text{No} \) No 12-13-67 Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 12-13-69 1 ☐ Yes 2X No White þ Specify: 3 ☐ Widowed 4 🏋 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Truck Driver Transportation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ... Pages 1 and 2 should be fill timent of Health and Mental H tant: if item 27 is marked ott jury or other traumatic avan Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ex-Wife 19481 Heritage Drive, Abingdon, VA 24211 Mary Osborne 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 □ Burial 2 ☑ Cremation 3 □ Removal from State permit. Page Department of importent: if any injury or once. 4 □ Donation 5 □ Other (Specify) Bayview Crematory, Inc. 11-21-2005 Baltimore, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Ambrose Funeral Home, Inc. /1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ruptured artic anunysm **Physician** /Medical **Examiner** Levoscherotic Cardiovascular discase Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Diractor: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the hours to the completely filled in by the funeral director, page 2 should be detached for use as the hours to the completely filled in by the funeral director. Due to (or as a consequence of): Records, P.O. Box 68760, Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probebly WUnknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ✓ Yes 2 □ No autopsy performed? 1 X Yes 2 No 2 No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1X Yes 2 □ No 1 Inpatient 2 ER/Outpatient At scene Certification: To 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

XXMedical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year November 16, 2005 29b. Signature and title of certifier 29c. License number OCME (Type, Print) 111 Penn Street Baltimore, Maryland 21201 13/46 32 Registrar's Signature 31. Date filed (Month, Day, Year) State

Registrar

State of Maryland / Department of Health and Mental Hygiene 1- State Amend Item 2 per dvr G849 11-22 Pariticals of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2005 3. Time of Death Physician November MAXWELL KEYES MUDGE 12:15A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Blakehurst Health Center Towson Baltimore, If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours November 22, 1926 1**X**XM 2□ F Mary land 213-28-4805 78 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits !7 is marked other than "netural", or items 23a or 28a-f show traumetic evant, the Medical Executer must be notiffed ≥ 1 Yes 2 XXX Funeral Director Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1055 West Joppa Road 21204 USA 12. Was Decedent Ever in U.S.

Armed Forces?

XIMM'ses 2 □ No WWII

If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married X2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes aXXXX White Specify Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Vice President Tractor Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Arthur Phillip Mudge Helen Harwood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 : Department of Health ar Important: if itam 27 is any injury or other trau once. 1055 W Joppa Road #253 Towson, Maryland 21204 Jacqueline Vernay Mudge Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2XX cremation 3 Removal from State 11-22-05 GreenMount Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc Signature of Funeral Service Licengee 6500 York Road Baltimore, Maryland 21212 mus 23a. Part1. Enter the diseas , or compliantions that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only the cause on each line. Approximate Interval Between Onset and Death shock, or heart failure. List only Immediate Cause (Final Pneumonia Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner If any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medical the SS IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 □Unknown 1 TYes Be Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No this certificate 1 ☐ Yes 2 No 25. Was case referred to-medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred . After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation M 2 Accident in by the 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number **D** 0034988 29b. Signature and title of certif 29d. Date signed (Month, Day, Year) 11/21/05 who completed cause of death (Item 23a) (Type, Print) Name and Rd#255. Lugherville, MD 21093 Nober 4, MD 32. Registrar's Signature State Registrar 2005

December Name (First, Mothes, Last)   Comment of the basis   December   Comment of the basis   December   Comment of the basis   December   Comment of the basis   December   Comment of the basis   December				For State Registrar	State of M	aryland		artment of tificate of			Mental Hy	giene Reg. M		3	762	29
Gene Willis Mills, Jr.  Rockville  Shady Grove Adventist Hospital  Rockville  Rockville  Rockville  Rockville  Rockville  Rockville  Rockville  Shady Grove Adventist Hospital  Rockville  Shady Grove Adventist Hospital  Rockville  Shady Grove Adventist Hospital  Rockville  Shady Grove Adventist Hospital  Rockville  Shady Grove Adventist Hospital  Rockville  Shady Grove Adventist Hospital  Rockville  Shady Grove Adventist Hospital  Rockville  Shady Grove Adventist Hospital  Rockville  Shady Grove Adventist Hospital  Rockville  Shady Grove Adventist Hospital  Rockville  Shady Grove Adventist Hospital  Rockville  Shady Grove Adventist Hospital  Rockville  Shady Grove Adventist Hospital  Rockville  Shady Grove Adventist Hospital  Rockville  Shady Grove Adventist Hospital  Rockville  Shady Grove Adventist Hospital  Rockville  Shady Grove Adventist Hospital  Rockville  Notice Adventist Hospital  Rockville  Notice Adventist Hospital  Rockville  Notice Adventist Hospital  Rockville  Shady Grove Adventist Hospital  Rockville  Notice Adventist Hospital  Rockville  Notice Adventist Hospital  Rockville  Notice Adventist Hospital  Rockville  Notice Adventist Hospital  Rockville  Notice Adventist Hospital  Rockville  Notice Adventist Hospital  Rockville  Rockville  Notice Adventist Hospital  Rockville  Rockville  Notice Adventist Hospital  Rockville  Rockvi		Planeial											v Year		Time of I	Death
Shady Grove Adventist Hospital  Functal Director  Functal Director  Formation Fig. 1  Shady Grove Adventist Hospital  Hospital  Hosp				Gene Willi	is Mills,	Jr.									6:20	$\mathbf{P}^{M}$
Function   Director		Examin	er							n of Death		40				
ST7-72-6675   12M 2   F   52   Yrs   Months   Days   Mours   Mr.   Maryland							n de discontinuo de la colonia			ar 24 Hrs	O Data of B	-th				- Caralina
Total Personal Pers											(Month, D	ay, Year,	) ' C	country)		roreign
17. Father's Name (First, Middle, Last)   18. Mother's Name (First, Middle, Maiden Sumame)   17. Father's Name (First, Middle, Last)   18. Mother's Name (First, Middle, Maiden Sumame)   18. Mother's Name (Fir						32					May 31	, L3	ri CC	агут	and	
17. Father's Name (First, Middle, Last)   18. Mother's Name (First, Middle, Maiden Sumame)   17. Father's Name (First, Middle, Last)   18. Mother's Name (First, Middle, Maiden Sumame)   18. Mother's Name (Fir		yland		10a. State 10b. County		10c. City,	Town or Lo	cation						10d. l	nside City	y Limits
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17. Father's Name (First, Middle, Last)   18. Mother's Name (First, Middle, Maiden Sumame)   17. Father's Name (First, Middle, Last)   18. Mother's Name (First, Middle, Maiden Sumame)   18. Mother's Name (Fir		23a	le	22 Grandin Circl	T											
17. Father's Name (First, Middle, Last)   18. Mother's Name (First, Middle, Maiden Sumame)   17. Father's Name (First, Middle, Last)   18. Mother's Name (First, Middle, Maiden Sumame)   18. Mother's Name (Fir		ep	Tue		Armed Forces?		. 13.	Was Decedent of f Yes, specify Cu	Hispanic C ban, Mexic	Origin? (Sp an, Puerto	pecify Yes or N o Rican, etc.)	0-			ndian,	
17. Father's Name (First, Middle, Last)   18. Mother's Name (First, Middle, Maiden Sumame)   17. Father's Name (First, Middle, Last)   18. Mother's Name (First, Middle, Maiden Sumame)   18. Mother's Name (Fir	36	s afte	Y F		If Yes, Give	No		1 □ Yes 2 🗓 N	Specif	fy:			Specify: W	hite		
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1	lan	2 sho and ie mu		19a. Informant's Name/Relationship (	Type, Print)		19b. Mailir	ng Address (Stree	at and Num	ber or Ru	ral Route Numi	ber, City	or Town, State,	Zip Coo	(e)	
1	2	and ealth m 27			-Laubach/S				ircle	, Roc		1				
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Physician (Medical Examiner)  The disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate Cause. Efficial disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate Cause. Efficient Underlying that initiated events resulting in death) Last  Due to (or as a consequence of):  ENCEPHALO PATHY  Due to (or as a consequence of):  ENCEPHALO PATHY  Due to (or as a consequence of):    FFEMALE: 23b. Was decedent pregnant in the past 12 months? in the	Ore	ges 1 t of H if ita or ot		·	Removal from State	cen	netery, crer	sition (Name of natory or other p awn	ace)	Nove						
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Physician (Medical Examiner)  The disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate Cause. Efficial disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate Cause. Efficient Underlying that initiated events resulting in death) Last  Due to (or as a consequence of):  ENCEPHALO PATHY  Due to (or as a consequence of):  ENCEPHALO PATHY  Due to (or as a consequence of):    FFEMALE: 23b. Was decedent pregnant in the past 12 months? in the	tim	t. Pa rtmen rtant: njury		14		Me	moria	1 Park		2	005	Koc			_	
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Physician Medical Examiner  To proper the part of the	*			shock, or heart failure. List only	plications that caused one cause on each li	d the death. ne.	Do not ent	er the mode of d	ring, such a	as cardiac	or respiratory	arrest,		Inte	rval Betw	/een
Due to (or as a consequence of):    ACUTE RENAL FAILURE				disease or condition	_ a			ART FA	ILURI	E						
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Sport Sport	1	uted	듵	cause. Enter Underlying Cause (Disease or injury				44								
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Sport Sport	30	ath ce trendi	an/	23b. Was decedent pregnant	1 Live birth	2 Fetal d	death 3□		су						Υ.	ear
Sport Sport		the a	ysic	1 ☐ Yes 2 ☐ No		t time of dea	ath 5□	Other (specify)						Juj		
PROSTATE CANCER		that the	P	Part II. Other significant conditions	contributing to death b	ut not result	ting in the u	nderlying cause of	iven in Par	11.	23e. Did	tobacco	use contribute	to the ca	use of de	ath?
POSITION OF SET OF STATE OF SET OF STATE OF SET OF	ds,	sign sign d be	d b	PROSTATE	CANCER						1 🗆	Yes 2	!□No 3□F	robably	4 20 Ur	nknown
Section   Continued   Contin	COL	w req beer shou	lete								24a. Wa	s an	24b. Were a	utonsy f	indinos a	vailable
Second   S	Re	he la e has age 2	m d								auto perf	opsy ormed?	prior to death?	comple	tion of ca	use of
examiner?    Compose   Com	ta	ifficet or, pë	0	25. Was case referred to medical					26 Pla	re of Dea			o 1	s 214	No	
27. Manner of Death   1   Natural   28a. Date of Injury   28b. Tim	>	/sicia s cert direct	00	examiner?	Hospital:	ent 2□E	R/Outpatier	t 3DDOA					6 □Other (So	ecifu)		
Natural   5   Pending investigation   6   Could not be determined   2   Accident   2   Accident   2   Accident   2   Accident   2   Accident   2   Accident   3   Suicide   4   Homicide   4   Homicide   2   Accident   4   Homicide	of	Phy er this	] :	27. Manner of Death	28a. Date of Inju	iry 2	28b. Time of	28c. In	ury at					ocny)		
3 Suicide 4 Homicide 5 Op 1 Op 1 Op 1 Op 1 Op 1 Op 1 Op 1 Op	jo	nding ath. r: Aft	atlo			y ( 6a)	injury			□No						
29a. Certifier (Check only one)  29a. Certifier 29a	V <sub>i</sub> S	er de recto by th	tifle	data-min-s	289. Place of in	ury - At hom	ne, farm, str	eet, factory, offic	9		28f. Location City or To	(Street al	nd Number or F	Rural Roi	ite Numb	1θΓ,
29a. Certifying Physician: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29a. Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	۵	itel or rs aft rel Di	Cer													
		e Hosp 24 hou e Fune letely fil	edical	(Check only 2 Medical Exa	miner on the basis of	f examination	ledge, deatl on and/or in	n occurred at the vestigation, in my	time, date opinion, d	and place eath occur	, and due to the rred at the time	cause(s , date an	s) and manner and du	s stated e to the	cause(s)	
29c. License number 29d. Date signed (Month, Day, Year)		To the within To the comp	M	29b. Signature and title of certifier	124 ) A	$\wedge$						29d. Da	ate signed (Mor	ith, Day,	Year)	
23 2154976/VV \ D0062435 NOVEMBER 17 200				1 23615	4796/	(VV		Do	062	435		NOVE	EMBER	17	200	05
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	-	1h				death (Item 2	23а) (Туре,	Print)	70	D.	<i>au</i>	- n	22 40	0 = 1		
50. Name and address of person who completed cause of death (Item 23a) (Type, Print)  SAYED ELSAYYAD 9715 MEDICAL CTR DR ROCKVILLE MD 20850		15			IAD 9	115 n	MEDIC	CAL CIK	DK	70	CKVILLE	: "	עי 20	050		
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	13				32. Hegisti	ar s oignatu	le 4	Carto								
State Registrar  DHMH 17 Rev 1/2001  State Rev 1/2001  NOV 2 2 2005	DH	74.5		NOV 2 2	2005	1	J. 1									

ORIGINAL

William T. Nierhaus 05-07778 crn

777	8		1 - State Unpend Item 2	State of Marylan 23a,27,28a-f p	d/Depa er me	artment C849 1 Tilicate	of Health	and Me	ental Hyg	jiene jiene	5	37630
3	Physici	an Se	1. Decedent's Name (First, Middle, Las	"					2. Date of Dea Month		Year	3. Time of Death
	/Medic	al		T. Nierhau	S 			1	Novembe	-	2005	12:46 P M
-	Examin	er	4a. Facility Name (If not institution, give Johns Hopkins Bayy		ont ou		own, or Locatio	on of Death				1
	Funeral		5. Social Security Number 6. Se	7. Age (In yrs.	iast birthday)	If Under 1		der 24 Hrs.	8. Date of Birth (Month, Day	N/	9. Birth	nplace (State or Foreign
*	Director			3 <sup>M</sup> 2□F 3	7 Yrs.	Months	Days Hours	s Min.	Jan 8,	1968	Mar	yland
	and		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Lo	cation						10d. Inside City Limits
	Maryl	tor	MD Balti	more	Ess	ex						1 Tes 2 No
	with the a or 28a	Director	10e. Street and Number 622 Delaware	Ave.		10f. Zip C	ode 1221		1	0g. Citizen of	What Col	untry?
	ms 23	Funerai	11. Marital Status	12. Was Decedent Ever in U.	S. 13.			Origin? (Spec	ify Yes or No- ican, etc.)		ce - Amer	ncan Indian,
036	within 72 hours after death with the Maryland ane. Then *ratural', or itams 23a or 28a-f show a Marylan Exariling radat be recilied at	Ď	1 ☐ Never Married 2 ② Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ∏Yes 2∑No If Yes, Give Year or Dates:		fYes, specify 1 ☐ Yes 🍇			ican, etc.)		ck, White y: Wh	
2 2	72 ho natur	eted	15. Decedent's Ed (Specify only highest grad	ucation de completed)	(Give	dent's Usual i	done during m	nost of working	a	16b. Kind of B	usiness/I	ndustry
121	within ene. then	Completed	Elementary/Secondary (0-12) 12th	College (1-4or 5+)	life.	DO NOT use	tal Me			LOca	al 1	00
_	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene is marked other then "ratural", or itams 23a or 28a-f show aumatic event, it a Marylan Examinar manter retition at	To Be Co	17. Father's Name (First, Middle, Last) George W. Nie	rhaus					(First, Middle, Hodg	Maiden Suman	ne)	
Mary	nd 2 shoulth and he was to ma		19a. Informant's Name/Relationship (7 MAry McGuire /							City or Town,		
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Itam 27 is marked eny injury or other traumatic ex <u>once</u> .		20a. Method of Disposition  1 Surial 2 Cremation 3 4 Donation 5 Other (Specify	Removal from State Oa	lace of Dispo emetery, crer KLawn	sition /Name	of	11/23	ite	20c. Location Baltin	- City or T	Fown, State
Baltir	permit. P Departme Importan eny injuri		21. Signature of Funeral Service Licens		22	. Name and	Address of Fac	cility Conr	nellyF	uneral	LHom	neofEssex
		, J	23a. Part 1. Enter the disease, or shock, or heart failure. List of the	Gundley		3	00 Mac	ce Ave	e. Bal	timore	≥ MD	21221 Approximate
	ate be executed /Medical /Medical /Medical Examiner	Ical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)	uence of): uence of):	nd Met	hadone)	)Intoxi	ication			Onset and Death
P.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1□Live birth 2□Fetal 4□Pregnant at time of di 9□Unknown	Ideath 3[	Ectopic preg Other (spec					ite of deliventh	very Day Year
rds, P	quires that n signed b	ρ Δ	Part II. Other significant conditions co	entributing to death but not resu	ulting in the u	nderlying cau	ise given in Pa	rt I.		bacco use cont	tribute to	the cause of death?
Records,	he ław requir. e has been si ige 2 should I	Completed							24a. Was a autops	SY Y	Were aut prior to co death?	topsy findings available ompletion of cause of
ta	an: T tificat tor, pa	BeCc	25. Was case referred to medical				26 Pla	ace of Death	Check only on	2 🗆 No	1 Yes	2 No
<u> </u>	ysici iis cer direc	To B	exeminer? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient	ER/Outpatier	it 3 DOA	04			ence 6 Oth	ner (Spec	u(v)
Division of Vital	nding Ph ath. r: After th e funeral		27. Manner of Death 1 □ Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury Fourth, Day Year) 11-18-05	28b. Time of Found 12:03	<b>P</b> M 280	. Injury at Work?			ow injury occur		unk
Divis	al or Atte after de i Directo d in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At ho building, etc. (Specify Found in car	v)	eet, factory,	office	28 I	If Location (Si City or Town	treet and Numb n. State) 550 Baltim	Pu	ra! Route Number, <b>laski</b> <b>M</b> d
	To the Hospital or Attending Physician: The law within 24 bours after death.  To the Funeral Director: Atten this certificate has completely filled in by the funeral director, page 2	Medical C	29a. Certifier 1 ☐ Certifying Phy (Check only one) 2 ☐ Medical Exam	/sician: To the best of my kno inar: On the basis of examina and manner stated.	wiedge, deat	n occurred at vestigation, in	the time, date n my opinion, d	and place, an	nd due to the c	ause(s) and ma	anner as	stated
	To the within To the Comp	ĕ	29b. Signature and title of certifier	. 000		29c. 1	License numbe		2	9d. Date signe	d (Month	, Day, Year)
)			1 talles	nica-tollal	W-S		O.C.M	.E.	N	lovember	: 19,	, 2005
			30 Name and address of person who o	ompleted cause of death (Item			14 ·	D 1 · ·			1 0 -	201
· 38	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signa		renn S	creet,	Baltin	nore, M	aryland	1 212	201
	Registr		NOV 2 2 2005	Marie St.	5034							

Judith K. Nuse 05-7696 AKG

			1 - For State Registrar	State of	Maryland		irtment of <i>tificate o</i>	Health and f Death		iene 0 0 5	37631		
	P. Division		1. Decedent's Name (First, Midd	lle, Last)					2. Date of Dea Month	Day Vo	3. Time of Death		
	Physici /Medio		Judith Kemp Nu						Novemb	er 13, 20	Ö5   5:00 A ™		
	Examin	er	4a. Facility Name (If not institution		•			, or Location of Dea	th	4c. County of D			
	27	*	Frederick Memor				Frederi			Frederi			
	Funeral Director		5. Social Security Number 220-48-8537	6. Sex 1 □ M 2  F	Age (In yrs. Ia:	st birthday) Yrs.	If Under 1 Year Months Day		. (Month, Day	Year) 9. 1945 Ma	Birthpface (State or Foreign Country) ryland		
	yland how		Usual Residence of Decedent  10a. State 10b. County	/	10c. City,	Town or Lo	cation				10d. Inside City Limits		
	B Ma	cto	Maryland Frede	rick	Frede	erick					1. Yes 2 □ No		
	다 다 6 28	lre	10e. Street and Number				10f. Zip Code	•	1	0g. Citizen of What	Country?		
	23a	al	600 Culler Ave	nue			21701		Į	JSA			
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumatic event. I'm Medical Examinar must be notified at once.	by Funeral Director	11. Marital Status  1 □ Never Married 2 ☒ Mar  3 □ Widowed 4 □ Divorce	If Yes Give	es? [X]No	i II	Vas Decedent o Yes, specify Cu ☐ Yes 2🌠 N	f Hispanic Origin? (Suban, Mexican, Puer lo Specify:	Specify Yes or No- to Rican, etc.)	Bfack, W			
21215-0036	hour tural	pa tr		nt's Education	35.	16a Deced	lent's Usual Occ	upation		16b. Kind of Busine	nite		
15	in 72	Completed	(Specify only highe	est grade completed)		(Give	kind of work dor	ne during most of wa	rking	166. Kind of Busine	ssindustry		
12	with iene. than	E G	Elementary/Secondary (0-12)	Cotlege (1-4		lustom	er Rela	tions Sup	ervisor	Insurance	Company		
	filed Hygin other		17. Father's Name (First, Middle,	, Last)		, a g G G a a	.01 11010		me (First, Middle,		Company		
Maryland	2 should be filed withir and Mental Hygiene. ie marked other than aumatic event, the Ms	To Be	Charles Harold	Hoover				Harriet	t Nelson	Kreh			
a	and and ie ma	0 6	19a. Informant's Name/Relation							, City or Town, State	e, Zip Code)		
	1 and 3 Health tem 27		James C. Nuse,	Jr., husba				venue, Fr	The same of the sa	Maryland	21701		
ore	of H of H if ite		20a. Method of Disposition 1 ☐ Burial 2 X Cremation	3 Removal from Sta	20b. Pla	ce of Dispos netery, crem	sition (Name of natory or other p	lace)	Date	20c. Location - City	or Town, State		
Ĕ	Pages ment of I ant: If its ury or o		4 □Donation 5 □ Other (S		Smit	hsbur	g Crema	tory $11/1$	5/2005	Smithsburg	g, Maryland		
Baltimore,	permit. Pag Department Important: I any injury o		21. Signatore of Funeral Service	Signatore of Funeral Service Lensee  22. Name and Address of Facility Keeney and Basform M00999 106 East Church Street, Frederic									
	-9%	23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one bause on each line.									Approximate Interval Between		
	Physician		fmmediate Cause (Final disease or condition		Hood	indur	06				Onset and Death		
	/Medical		resulting in death)	a Due to (or	as a conseque	ince of):							
	Examiner		Conventiothy list annulaines										
7	7 -	ner	Sequentially list conditions, if any, backing to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a conseque	nea off-							
V	cuter	Examiner	that initiated events	c									
oʻ	e exe ien a urial-i		resulting in death) Last	Due to (or	as a conseque	nce of):							
68760,	icate be executed physicien and s the burial-transit	edical		d									
	ing plans to		IF FEMALE:	T									
.O. Box	The law requires that the death certificate be executed tie has been signed by the attending physicien and tage 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☑ Unknown		n 2 ☐ Fetal d It at time of dea	eath 3	Ectopic pregnar Other (specify)	ncy		23d. Date of Month	delivery Day Year		
ls, P.	ires that signed b	þ	Part II. Other significant conditi	ions contributing to deat	h but not result	ing in the un	derlying cause	given in Part I.			e to the cause of death?  Probably 4 XiUnknown		
0	w requir been si should	etec			·				, <u>, , , , , , , , , , , , , , , , , , </u>		Tiobaciy 4 Albinkilowii		
Division of Vital Records,	eiaw hast je2s	Completed							24a. Was a autops	y prior	autopsy findings available to completion of cause of		
E	: Th cate	Ö							1 X Yes				
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medica examiner?	Table 1 - 14-1					ath (Check only on	Θ)			
of	this aldir	ပ္	tXXYes 2 □ No		-	R/Outpatient	3 DOA			ence 6 Other (S	pecify)		
n c	ing F	Certification:	27. Manner of Death 1 □Natural 5 □ Pendi	119		8b. Time of Injury	28c. in	ork?	28d. Describe ho	ow injury occurred	subject fell		
Sic	l or Attending I efter death. Director: After I in by the funer	cat	2 Accident invest 3 ☐ Suicide 6 ☐ Could	not he		und 2:		□Yes 2 No	00/ 1				
Ξ	or A	ŧ	4 Homicide determ	nined 289. Place of building	, etc. (Specify)		et, factory, offic	θ	City or Town	reet and Number of n, State) 600 (1	Rural Route Number,		
	urs e erai E					ene			Frederick	, MD			
	To the Hospital or Attending Physician: The law within 24 hours effect death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical	29a. Certifier 1 ☐ Certifyi (Check only 2 X Medical one)	ng Physician: To the be I Examiner: On the basi and manner	s of examinatio	edge, death in and/or inv	occurred at the estigation, in my	time, date and place opinion, death occi	e, and due to the caurred at the time, d	ause(s) and manner ate and place, and c	as stated. fue to the cause(s)		
	Vithin Forth	Me	29b. Signature and title of certific	ər			29c. Lice	nse number	-2	9d. Date signed (Mo	onth, Day, Year)		
	> - 0		Dunt Com	Shall MA			0.0	.M.E.	I	November 1	L5, 2005		
	.0 /		30. Name and address of person	who completed cause	of death (ftem 2	(Type F	Print)	· · · · · · · · · · · · · · · · · · ·			•		
	12		Pamela E. G		(Itom E		-	Street.	Baltimore	e, Marylar	nd 21201		
	Sta	te	31. Date filed (Month, Day, Year		istrar's Signatu					- , у л.сп			
33	Registr		NOV 2 2	2 2005	istrar's Signatu	GO	HELD						

publical known as Lucherta Owens

DHMH 17 Rev 1/2001

Amend Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. The State of Maryland / Department of Health and Mental Hygiene 15 1- For State Registrar Amend Item #20b PER FH G850 Qentile #05 of the eath Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** ueberta 12:55 AM 13 Novembe 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sina: It ospitul of Baltinone Baltimore City If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 228-42-5489 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 6. Sex Birthplace (State or Foreign **Funeral** Days 2 Months Hours 1 □ M 200 F Director Decil, Virginia Usual Residence of Decedent Maryland 10b. County 10d. Inside City Limits 10a, State 10c. City. Town or Location 7 is marked other then "naturel", or Items 23s or 28s-f show traumatic event, the Mudical Examinar must be notified at 1XYes 2 No 1timore Director Marviand 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces? 2/2/ Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 2 No 1 Never Married 2 Marned ☐ Yes Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: ð If Yes, Give Year or Dates: 3 ☐ Widowed 4 X Divorced DIAC Completed 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 should be filed wi h and Mental Hygien 7 le marked other th 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Kober 19a. Informant's Name/Relationship (Type, Print) (neplew) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Balto If item 27 Md. 21216 uthorne 16 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State ŏ 12/15/05 permit. Page Department of Important: If ony injury or once. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Joseph L. Kuss Funeral Home, P.A. 2222 W. North Ave. Barto Md. 21216 23a. Parti Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shopt, or heart effure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Cardiopulmenary arrest disease or condition resulting in death) day /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of): heroscieratic sides and the second transfer any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last heart Examiner physicien and s the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 X No page 2 s congestive certificate has 1 Yes 2 No director, Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 😿 No P 1 Inpatient 2 ER/Outpatient 3 DOA siyi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. 28d. Describe how injury occurred Certification: Injury at Work? the Hospital or Attending 1 Natural 5 Pending investigation Injury s after de-1 Tes 2 No 2 Accident n 24 hours after der ne Funerel Directo blately filled in by th 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 Mastaran Ra RES- 000 MO November, 13, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rafiei, MD Sinai Hospital of Baltinone Nastaran 31. Date filed (Month, Day, Year) 32\_Registrar's Signature State Registrar 2005

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 9:56 AM 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ounty Howard General Hospital Columbia Md Howard 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth | Months | Days | Hours | Min. (Month, Day, 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Year) 1 ☐ M 2 X F 65 Director 415-66-4291 Alabama Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits in than "natural", or items 23a or 28a-f show the Madical Examinar author notified at MD Director Howard 1 ☐ Yes 2 X No Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5900 Millrace Court, Unit A104 21045 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 (XNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes X No Specify. 3 Widowed 4 Divorced White other than "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygien Important: If Item 27 is marked other tt any injury or other traumatic event, ITE ODGE. Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Hugh Crews Katie Tapia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5900 Millrace Ct., Unit A104 Leonard H. Ponder, husband Columbia, MD 21045 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 11/21/05 Baltimore, MD 21. Signature of uperal Service Licentee Cremation Society of Maryland, Inc. George E. 299 Frederick Rd. 21228 Baltimore, MD MacNabb Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition **Physician** hock hr /Medical resulting in death) Due to (or as a consequence of). **Examiner** intestine Gangrenou large and small Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit and resulting in death) Last Due to (or as a consequence of): the attending physician thed for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4 Pregnant at time of death 5 Other (specify) be detached 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has autopsy performe 1 🗌 Yes 3 No or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one, examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certification: To 1 Yes Inpatient 2 ER/Outpatient 3 DOA 27. Manger of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Natural 5 Pending 1 Tes 2 No investigation 2 Accident the Director: 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Homicide within 24 hours a Telegraphy of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D3445

State Registrar

31. Date filed (Month, Day, Year) 2 2005 DHMH 17 Rev 1/2001

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MD

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

Little

ADH WILLIAM EDWARD PRUITT 05-7845

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DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** November 0550 George Albert Paulman, Sr. 21 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MEMORIAL HOJPITAL If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | May 4, 1917 TALBOT EASTON 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**⋈** M 2□ F Yrs. Director 215-09-8220 88 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits worle Item 27 is marked other than "naturel", or items 23s or 28s-f show other traumatic event, the Madical Examinan must be rutified at 1 ☐ Yes 2 No Directo Maryland Queen Anne Grasonville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 112 Aslan Court 21638 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 ☑ Yes 2 □ No If Yes, Give Year or Dates: 1944–46 1 Never Married 2 Marned Maryland 21215-0036 1 ☐ Yes 2X No White Specify: Specify: Ď 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) ies 1 end 2 should be filed wi of Health and Mental Hygien If item 27 ie marked other th police officer City of Baltimore 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Carl Elmer Paulman Margaret Hauf 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 end 2 Department of Health at Importent: If Item 27 le any injury or other trau George Paulman, Jr. - son 112 Aslan Court, Grasonville, Maryland 21638 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lorraine Park Cemetery 11/23/05 Woodlawn, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. KOWE 4107 Wilkens Avenue, Baltimore, Maryland 21229 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final a RIGHT MIDDLE CEREBRAL ARTERY INFARCTION **Physician** /Medical resulting in death) Due to (or as a consequence of): Examiner ATRIAL FIBRILLATION 11/16/05 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal dea
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Year Day 5 Other (specify) 1 Yes 2 No ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, p CHRONIC アノルトトロのノノノに LEUKEMIA Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown RESPIRATORY 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 Yes 2 1 No 1 ☐ Yes 2 TNo Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Matural 5 Pending М 1 Yes 2 No death. investigation 2 Accident within 24 hours after death To the Funerel Director: the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) à 4 - Homicide filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) ro the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OMA D 63726 11.21.05 MD MEMORIAL HOSPITAL EASTON 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAJERODUNMI KUNMI am 219 S. WASHINGTON ST. EPSTON MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

			For State Registrar	State of Maryland		nt of Health a te of Death		giene	37636
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. Bo	e atter	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnand 1 ☐ Live birth 2 ☐ Fetal d 4 ☐ Pregnant at time of dea 9 ☐ Unknown	death 3 Ectopic			23d. Date of del Month	ivery Day Year
	been signed by the s should be detached		Part II. Other significant conditions of Recurrent	Tiffehm a	ting in the underlying \( \begin{align*} \text{V.e.s.} \te	cause given in Part I.	23e. Did t	obacco use contribute to Yes 2 2 0 3 Pr	o the cause of death?
Reco	has b	Completed by	morbid 0	Besity ?	/		24a. Was auto perio	psy prior to or death?	stopsy findings available completion of cause of
of Vital	is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:		0#	1 ☐ Yes of Death (Check only of	one)	
on of	After this uneral dir	lon: To	1 Yes 2 6  27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)		28c. Injury at Work?	28d. Describe	dence 6 Other (Specification)	cify)
Division of Vital Records,	within 24 hours after death.  To the Funerel Director: After th completely filled in by the funeral	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		M ne, farm, street, facto	1 ☐ Yes 2 ☐ N		Street and Number or Ru wn, State)	ural Route Number,
Hospita	24 hours Funere	edica C	29a. Certifier 1 // Certifyin ; Ph (Check only one) 2   Medical Exam	ysician: To the bast of my knowl iner: On the basis of examination and manner stated.	ledge douth uccurson and/or investigation	d at the time, date and on, in my opinion, death	place, and dus to this a occurred at the time,	date and place, and due	stated: to the cause(s)
To the	within To the comple	Mec	29b. Signature and title of certifier	Il A	25	9c. License number	01/	29d. Date signed (Monti	h, Day, Year)
9	10		30. Name and advess of vision while	compl. ed cause of eath (Item 2	23a) (T. pe, Print	0200	k 1/2	4 10	J
, O	Sta	te	31. Date filed (Month, Day, Year)	32. Register's Signatu	I Made J	on jon	erily	Wille DUIN	119,440, 2106
18.	Registi	ar	NUVZ	2005	It Bra	and a			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year  $A^{M}$ James L. Price November 14 2005 9:49 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson St. Joseph's | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Day Year) | O5-12-1952 6. Sex 1 M 2 □ F 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 216-54-1851 53 Yrs Maryland Director Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1X Yes 2 □ No Director MD **Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or USA 21217 501 Dolphin Street Apt 615 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: "neturel", or Items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after o Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel; or hen any injury or other traumatic event, the Medical Examinations. Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Black 2 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 Cook Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Orange Windley Mary Ann Banks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan E. Harris/Cousin 1149 Myrtle Ave Baltimore, MD 21201 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Baltimore, MD 11-19-05 ' 4 ☐ Donation 5 ☐ Other (Specify) Arbutus Memorial Park 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Jones thementa Wylie Funeral Home 638 N. Gilmor St. Balto, MD 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) terminal Acquired immuno deficient Physician /Medical Due to (or as a consequence of) Examiner Due to (or as a consequer Sequentially list conditions, if any, leading to limit ediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the attending physician and the or use as the burial-transit requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy be detached for Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) Records, P.O. 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an has autopsy performed? 2 No 1 Yes Division of Vital all or Attending Phyelcien: Ts after death.

I Director: After this certificat or in by the funeral director, pa 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 2 3□ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27 Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \( \text{Homicide} To the Hospital o within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Min - p Kions 031865 Klionne (mion-Door Company and acceptable to person and compatted cause of death (Item 23a) (Type, Print) autan Rm 206 street md 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene 🕦 🕦 🖔 1 - Stata Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November 21, 2005 **Physician** 4:55 George Ronald Ross Ам /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 636 Dunwich Way Essex Baltimore Hours Min. 8. Date of Birth (Month, Day, Year) Feb. 6, 1946 If Under 1 Year Months Days 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** iXM 2□F 215-44-1633 59 Virginia Director Usual Residence of Decedent 10a, State 10b. County 10c. City Town or Location 10d. Inside City Limits r than "natural", or Items 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2000 Completed by Funeral Director Maryland Baltimore Essex 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 636 Dunwich Way 21221 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 222 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural, or Item any Injury or other traumatic event, the Marical Examera 1 Never Married 2 Married 21215-0036 1 ☐ Yes ŽXNo Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9 Heavy Equipment Operator Waste Treatment Plant Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Minnie Sutphin George Riley Ross ျှ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 636 Dunwich Way, Baltimore, Maryland 21221 Brenda Ross (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 25 Cremation 3 Removal from State 20a. Method of Disposition 20c. Location - City or Town, State Bayview Crematory, Inc. 11/23/2005 | Baltimore, Maryland 21. Signature of Funeral Service Linens 22. Name and Address of Facility Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** anc /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) or Attending Physicien: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760. use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery atter for u 3 Ectopic pregnancy in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) P.O. I 1 ☐ Yes 2 ☐ No 6 signed be det Part II. Other significant conditions contributing to death bul not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☑ No 24a. Was an page 2 autopsy performe certificete 1□ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Cther: 4 ☐ Nursing Home 0 1 Yes ≥ No 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b Time of 28d. Describe how injury occurred Medical Certification: 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A
completely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Momicide 29a. Certifier and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License numbe 0, ted cause of death (Item 23a) (Type, Print) and address of person who compl 31. Date liled (Month, Day, Year) 32. Registrar's Signature State 2 Registrar

			1 - For State Registrar		aryland / Dep	artment of Health a rtificate of Death	and Mental Hygic	•	37639
	Physic		1. Decedent's Name (First, Middle, La Elizabeth J. Rod		_		2. Date of Death Month	Day Yea	3. Time of Death
	/Medi Exami		4a. Facility Name (If not institution, give		)	4b. City, Town, or Location of	f Death	4c. County of De	
			Upper Chesapeake	Medical	Center	Bel Air		Harford	ĺ
1	Funeral	2.0	Social Security Number 6. S	Sex 7. Ag	ge (In yrs. last birthday)	If Under 1 Year If Under 2 Months Days Hours	Min. (Month, Day, )	(ear) 9. E	Birthplace (State or Foreign Country)
9	Director		215-14-4916 Usual Residence of Decedent  10a. State 10b. County	X	10c. City, Town or Le	anatic a	May 24,	1921   Pe	ennsylvania
	e Maryla 8a-f shov	ctor	Md. Harfo	ord		lington			10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	dith th	Dire	10e. Street and Number			10f. Zip Code	100	g. Citizen of What	Country?
10	e 23e	rai	1135 Main Street	12. Was Decedent	Everin II C 10	21034	i-0/6	U.S.A.	
062	I.K. I.D-UUJO within 72 hours after death with the Maryland ane. than "natural; or items 23s or 28s-f show the Medical Exarts or must be radified at	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	Armed Forces:  1  Yes 2  If Yes, Give Year or Dates:	No No	Was Decedent of Hispanic Orig If Yes, specify Cuban, Mexican 1 ☐ Yes 2 ☐ No Specify:	in? (Specny Yes or No- , Puerto Rican, etc.)	Black, WI	merican Indian, hite, etc. white
000	hin 72 hou	Completed	15. Decedent's E (Specify only highest gra	ade completed)	(Give	dent's Usual Occupation kind of work done during most DO NOT use retired)	of working	3b. Kind of Busines	ss/Industry
5		E	Elementary/Secondary (0-12) 7 years	College (1-4or		stant	r	hysical	therapy
		Be	17. Father's Name (First, Middle, Last	)			r's Name (First, Middle, Ma		
, 3	Vicinity Ment	2	unknown			unkno	own		
05	0,00	1	19a. Informant's Name/Relationship (			ng Address (Street and Number			
			Thomas M. Rodney	, Sr./husi		Main Street,		Md. 2103 Dc. Location - City of	
1/18/05	2 2 2 2		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif		' I	osition (Name of matory or other place)  Cemetery 1		Baltimore	
, i	permit Pag Department Important: I		21. Signature of Funeral Service Licer	1 1	22	2. Name and Address of Facility	al Home of B	Rol Air	Tnc
1	10240		23a. Part1. Enter the disease, or comshock, or heart failure. List only	nlications that have	d the death. Do not see	10 W. MacPhail	Road, Bel A	ir, Md.	21014 Approximate
			shock, or heart failure. List only	one cause on each i	ine.	er the mode of dying, such as t	ardiac or respiratory arres	Ι,	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. CECT Due to (or as	a consequence of):	piratory	Arrest		Few Minutes
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300002	be executed sicien and burial-transit	cal Ex	1030/king in death) Last		a consequence of):	`			1111
4 3	fficate filters the tas the t			d. Jean	to year				[ Wills
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	that the	y Ph	Part II. Other significant conditions of	contributing to death b	out not resulting in the u	nderlying cause given in Part I.	23e. Did toba	cco use contribute	to the cause of death?
去	v requires been sign should be	ed b	HIN, An	2 cmie	, Sm	sker, Kids	Yes	2 No 3 1	Probably 4 Dunknown
abeth	The law requate has been page 2 should	omplet	Cancer S	17 Ne	phrecton	>' / COPD	24a. Was an autopsy performe	prior to death?	
1,2a		(a)	25. Was case referred to medical			26 Place	1 ☐ Yes 2X of Death (Check only one)	No 1□Ye	es 2 No
_ >	Physician: This certific ral director,	ToB	examiner? 1 ☐ Yes 2 2 No	Hospital: 1 Inpatio	ent 2 ER/Outpatier	Other	sing Home 5 🗆 Residence	ce 6 □Other (Sc	Decify)
A S	ing After une	ion:	27. Manner of Death  Description 5 Pending	28a. Date of Inju (Month, Da	ury 28b. Time o ly Year) Injury	Work?	28d. Describe how	injury occurred	
Rodney, Division	or Attendent ifter death Director: in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not b 4 Homicide determined	e 28e. Place of In	jury - At home, farm, str tc. (Specify)	M 1 ☐ Yes 2 ☐ N eet, factory, office		et and Number or I State)	Rural Route Number,
Roca	spital ours seral filled	Medical Co	29a. Certifier Check only one) Check only 2 Medical Exer	nysicien: To the best niner: On the basis o and manner st	it examination and/or in	n occurred at the time, date and vestigation, in my opinion, death	place, and due to the cause occurred at the time, date	se(s) and manner a	as stated. ue to the cause(s)
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier	1		29c. License number	29d	. Date signed (Mor	nth, Day, Year)
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_	6		30. Name and address of person	111 20	death (Item 23a) (Type,		2 0		2122
	St	ato	31. Date filed (Month, Day, Year)	Registr	ar's Signature	by Dr. # 3	icy balta	more MP	21237
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	Dhamiai		1. Decedent's Name (First, Middle, La	st)				2. Date of Death Month	Day Ye	3. Time of Death		
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	Examir		4a. Facility Name (If not institution, give	e street and number	r)	4b. City, Town, o	or Location of Death		4c. County of D			
			FOREST HILL HEAL	TH & REHA	B CENTER	FORE	ST HILL		HAR	FORD		
	Funeral		5. Social Security Number 6. S		ge (In yrs. last birthday)			8. Date of Birth		Birthplace (State or Forei Country)		
	Director		213-20-9516	□M 2√2F	100 Yrs.	Months Days	Hours Min.	(Month, Day, ) 10/25/19				
	П		Usual Residence of Decedent		100			110/25/19	US   M	aryland		
	ylan Mow		10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limi		
	Man	to	MD Harford	3	Forest	Hill				1 Yes 2		
	28 g	Director	10e. Street and Number		101000	10f. Zip Code		100	g. Citizen of What	Country?		
	with se or									002		
	eath	era	515 Wicklow Con	12. Was Deceden	t Ever in II S 13	21050	Hispanic Origin? (Sp		U.S.A.	mencan Indian.		
	ltan Itan	Funeral	1 ☐ Never Married 2 ☐ Married	Armed Forces	3?	If Yes, specify Cub	an, Mexican, Puerto	Rican, etc.)	Black, W			
36	is af	by F	3 √Widowed 4 □ Divorced	1 Yes 2 If Yes, Give	Δ.	1□Yes 2\XNo	Specify:		Specify:			
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N	llad Hygid Thar		12 17. Father's Name (First, Middle, Last,	<del></del>	Mul	ti-Tasker				Industries		
Ĕ	be f ntal h d of	Be	17. Father's Name (First, Micole, East,	'			is. Mothers Nam	e (First, Middle, Ma	uden Sumame)			
Maryland	Mer Mer Mark Mark	2	Samuel Taylor					/irginia	a Bevans			
ā	2 sh and ls m		19a. Informant's Name/Relationship (	Type, Print)	19b. Maili	ng Address (Street	and Number or Rui	al Route Number, (	City or Town, Stat	e, Zip Code)		
	and saith n 27		Anna M. Reinecke	e (dtr.in-	-law) 51 20b. Place of Dispo		Court -	Forest H	ill, Mar	yland 21050		
altimore,	of H fitar		20a. Method of Disposition	Domovol from Stat	ce)	Date 20	c. Location - City	or Town, State				
Ĕ	Pag nent nt: I		1   Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specif	altimoro	Maryland							
Ħ	nit.		21. Signature of Funeral Service Licer									
m	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if itam 27 is marked other than "natural", or itams 23a or 28a-f show any injury or other traumatic event. The Marical Examinet must be notified at once.		FER ST Y	ssahns	1	1750 D.1-				ral Home, P		
	100		23a. Part1. Enter the disease, or com		ed the death. Do not en	ar the mode of dvir	on such as cardiac	or respiratory arres	ile, Mar	vland 2108		
			shock, or heart failure. List only Immediate Cause (Final	one cause on each	line.			o. 100pinatory arros	4.9	Interval Between Onset and Death		
	Physician		disease or condition resulting in death)	a	s a consequence on:	devial	em					
	/Medical Examiner					1						
В		L	Sequentially list conditions,	b. —								
7	sit sit	Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or a	s a consequence of):							
$\sqrt{}$	acute and tran	am	that initiated events resulting in death) Last	c								
Ö	e ex		1930iting in Geath) Last	Due to (or a	s a consequence of):							
68760	ate b nysic he b	ica		_ d								
9	eath certificate be executed attending physician and for use as the burial-transit	an/Medical	IS SSMALS	47,000		-			1			
Вох	h ce endii	an/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	e of pregnancy 2 Fetal death 3	Tectonic programa	,		23d. Date of			
	deal e att		in the past 12 months? 1 \( \subseteq \text{Yes}  2 \subseteq \text{No} \)	4 Pregnant		Other (specify)	,		Month	Day Year		
ö	t the by th	Physici	9 🗆 Unknown	9□ Unknown								
	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-Itansis	ру Р	Part II. Other significant conditions of	ontributing to death	but not resulting in the u	nderlying cause giv	en in Part I.	23e. Did toba	cco use contribute	to the cause of death?		
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Vital	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?					h (Check only one)				
0	S S	P	1 ☐ Yes 2 ☐ No	Hospital: 1 Inpai	tient 2 ER/Outpatie	nt 3□ DOA Oth	er. Nursing Ho	me 5 🗆 Residend	ce 6 □Other (S	pecify)		
	ding Ph n. After th funeral		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of In (Month, D	jury 28b. Time o	f 28c. Injur Wor	y at	28d. Describe how	injury occurred			
Division	Attanding r death. actor: After by the fune	ertification;	2 Accident investigation	1	,,		Yes 2 □ No					
S S		tific	3 ☐ Suicide 6 ☐ Could not b	286. Place of I	njury - At home, farm, st	reet, factory, office				Rural Route Number,		
	al or s afte ni Dir	Cert		Dunding,	sto. (up <del>o</del> uty)			City or Town,	3(4(0)			
	Hospital 24 hours a Funaral I tely filled		29a. Certifier 1 Sertifying Ph	ysician: To the bes	t of my knowledge, deat	h occurred at the tir	me, date and place,	and due to the cau	se(s) and manner	as stated.		
	- /4 - O	edical	(Check only 2 ☐ Medical Exar one)	ninar: On the basis and manner:	of examination and/or in	vestigation, in my o	pinion, death occur	red at the time, date	and place, and o	due to the cause(s)		
	To the I within 2 To the	Me	29b. Signature and title of certifier			29c. Licens	e number	29d	I. Date signed (Mo	onth, Day, Year)		

State Registrar 31. Date filed (Month, Day, Year) NOV 2 2 2005

DR. DAVID DUNN

651 W. MACPHAIL ROAD 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

**ORIGINAL** 

035532

BEL AIR, MD.

			For State Registrar	State of Maryla		ertment of H tificate of L			ene 2005	37641
,:*(	Physici	an	1. Decedent's Name (First, Middle, Li					2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al	IHOMAS J.	KONEY		4. Ch. Tour	I fi f D sh	November		
	Examin	er	4a. Facility Name (If not institution, gi	E MEDICAL CE	UTER		Location of Death		4c. County of Dea	
	Funeral		5. Social Security Number 6.	Sex 7. Age (In y	rs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9 Rin	thplace (State or Foreign
	Director		171-40-2647	1 DM 2□F 58	Yrs.	Months Days	Hours Min.	(Month, Day, ) March 10	0 1947 P	A
	and		Usual Residence of Decedent  10a, State 10b, County	10c.	City, Town or Lo	cation				10d. Inside City Limits
	Maryl f aho	tor	MD Baltimo	ire	Cockey	vsville				1 ☐ Yes 2 No
	death with the Maryland ms 23a or 28a-f ahow	Director	10e. Street and Number		- dodo/	10f. Zip Code		100	g. Citizen of What Co	ountry?
	th with		217 St. David C	t.		21	030		USA	
	tems	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	n U.S. 13. V	Vas Decedent of Hi f Yes, specify Cubar	spanic Origin? (Spe n, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
36	rs afte	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ∐Yes 2 X No If Yes, Give Year or Dates:	1	I□Yes 2【XNo	Specify:		Specify: W	nite
ş	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other than "natural", or lieums 23a or 28a-f show aumatic evant, the Martical Exam and martic evant, the Martical Exam and martic evant.		15. Decedent's I	Education	16a. Deced	lent's Usual Occupa	ation	16	6b. Kind of Business	/Industry
222	thin 7 e. an "n	Completed	(Specify only highest g Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	KING OF WORK GONE O DO NOT use retired,	luring most of workir )	7g		
Maryland 21215-003	ed wil	Con	12	5+	Fami	ly Physic			Medical	
מחמ	be fil be oth be oth evan	Be	17. Father's Name (First, Middle, Las				18. Mother's Name			
<u>=</u>	should ind Men s marke umatic	2	Thomas Herron  19a. Informant's Name/Relationship		19b Mailin	n Address (Street a	Agnes M		City or Town, State, .	Zin Code)
_	and 2 sealth an n 27 ls		Nicole M. Roney						PA 1522	
o	is 1 and 2 of Health itam 27 other tr		20a. Method of Disposition	20	b. Place of Dispo-		D	ate 20	0c. Location - City or	
Ē	Pages nent of I ant: If its ary or o	1	1 XBurial 2 Cremation 3 4 Donation 5 Other (Spec	☐Removal from State			"   11/2 al Garden	3/05 S	Fallston,	MD
Balt	permit. Pages 1 and 2 should Department of Health and Men Important: If itam 27 Is marke any injury or other traumatic once.	(	21 Signal a of Funeral Service Lice	ensee	22 L	. Name and Addres	ss of Facility uneral Ho	ome of D	ulanev Va	allev, Inc.
	⊄ C1 7 % C4		23a. Part1. Enter the disease, or con	Lemmon					ulaney Va um, MD 2	1093 Approximate
	nysician /Medical Examiner		shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	a	NARY	EM BOL				Interval Between Onset and Death Hours
/ '	icate be executed physician and s the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter fur anything Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a conc.  Due to (or as a conc.						
8760	cate be	dlcal		d						
.O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pre 1□Live birth 2□f 4□Pregnant at time 9□Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
rds, P.	w requires that been signed by should be deta	by	Part II. Other significant conditions	contributing to death but not	resulting in the ur	nderlying cause give	en in Part I.		_	o the cause of death?
		Completed						24a. Was an autopsy performs	prior to	utopsy findings available completion of cause of
Vital	Attending Physician: Th r death. actor: After this certificate by the funeral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		0	26. Place of Death	(Check only one)	)	
	S S	. To	1 ☐ Yes 2 No 27. Manner of Death	1 ☐ Inpatient	2 ER/Outpatien 28b. Time of		4 Li Nuising non	ne 5 Residen 28d. Describe how	ce 6 Other (Spe	cify)
no	ding I h. After funer	tlon	1 Natural 5 Pending 2 Accident investigati	(Month, Day Yea	r) Injury	Work	(? Yes 2 □ No	DO. DESCRIBE NON	injury occurred	
Division of	il or Attending Ph after death. I Diractor: After th d in by the funeral	Certification;	3 Suicide 6 Could not determine	be 280 Place of Injury -	At home, farm, streecify)	eet, factory, office	2	28f. Location (Stre City or Town,	eet and Number or Ri State)	ural Route Number,
	To tha Hospital or Attentwithin 24 hours after deatl to tha Funeral Diractor: completely filled in by the	Medical C		Physician: To the best of my aminer: On the basis of examand manner stated.		vestigation, in my or	pinion, death occurre			
	To ti withi To ti comp	Σ	29b. Signature and title of certifier	(D)		29c. License			d. Date signed (Mont	
	/		1 ober	1 Cales	WND	1) Wa	7740		11/19/00	5
	15		ROBERTA. PALERA	o completed cause of death	(Item 23a) (Type, 1C 6 101	N.CHARL	ES STREE	ET, BALT	TIMORE, /	nD.21204
**	Sta Regist		31. Date filed (Month, Day, Year) NOV 2 2 2	005 Hegistrar's S	S. Son	ules.				

			1 - For State Registrar	State of M	laryland		artment rtificate			and M		jiene og. No. 0	5	37642	
	Physici		1. Decedent's Name (First, Middle, Virginia M.	,							2. Date of Dea Month Novembe	Day	Year	3. Time of Death	
	/Medic Examir		4a. Facility Name (If not institution,		r)		4b. City, T	own, or	Location o	of Death	Novembe	4c. County		h	
	LXXIIII	ici	Mariner Hea	1th Care					Caton	svi1	.le	Baltimore			
	Funeral		5. Social Security Number		ge (In yrs. la	ast birthday)	If Under	1 Year Days	If Under	24 Hrs. Min.	8. Date of Birth	) Year)	9. Birti	nplace (State or Foreign untry) Cyland	
	Director		216-10-3394	1□M 2 <b>1</b> 0F	85	Yrs.	WOTTE	Days	110015	WIII.	Apr. 8,	1920	Mar	yland	
	and		Usual Residence of Decedent  10a, State 10b, County		10c. City.	, Town or Lo	cation							10d. Inside City Limits	
	Mary!	ō	MD Ba	ltimore				ons	ville	:				1 ☐ Yes 2X No	
	the 1	Director	10e. Street and Number				10f. Zip (	Code			1	0g. Citizen of	What Co	untry?	
	h with		98 Smithwood Av	enue					2122	.8		United	Sta	ites	
	deat deat	Funeral	11. Marital Status	12. Was Deceden Armed Forces	t Ever in U.S	5. 13.	Was Decede	ent of His	spanic Orig	gin? (Spe	ecify Yes or No- Rican, etc.)			rican Indian,	
98	or It	y Fu	1 ☐ Never Married 2 ☐ Marrie		No	i	1 □ Yes 2			i, Fuerto	rican, etc.)	Specif	ck, White	nite	
Ö	within 72 hours after death with the Maryland ene. then "natural", or Items 23a or 28e-f show he Medical Ezairane must be notified at	d by	3 Widowed 4 □ Divorced	Year or Dates	:								, ·		
7	in 72 "na" r	Completed	15. Decedent's (Specify only highest	grade completed)		(Give	dent's Usual kind of work DO NOT use	done d	uring most	of worki	ng	16b. Kind of B	usiness/l	Industry	
212	filed with Hygiene. Ither ther	mo	Elementary/Secondary (0-12)	College (1-4or	5+)		Homen					C	wn H	Iome	
פ	e filed al Hygi other vent.	BeC	17. Father's Name (First, Middle, L	ast)					18. Mothe	r's Name	(First, Middle,				
<u> a</u>	Menta	ToE	Frank Shaw							He1e	n Davis				
Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours atter death with the Marylan It of Health and Mental Hygene. If item 27 is marked other then "natural", or Items 23a or 28e-f show or other treumetic event. The Medical Examinations is a collined at		19a. Informant's Name/Relationshi			19b. Mailir	ng Address	(Street a	nd Numbe	r or Rura	l Route Number	r, City or Town,	State, Z	(ip Code)	
6	of Health item 27 I			Daughter	20h Bis				7		tus, MD		- Civ	-	
Baltimore,	Pages nent of h					ace of Dispo metery, cren			- 1			20c. Location			
≝	it. Partitude introduced introduc			6	Lou										
Ba	parmit. Page Department Important: If eny injury or once.		DAMA OVV	Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify)  Coudon Park Cemetery 11-22-2005 Baltimore 22. Name and Address of FacilityAmbrose Funeral Home, 1328 Sulphur Spring Rd., Arbutus, MD 2 Part. Enter the disease, or complications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Est only one cause on each line.											
			23a. Part1. Enter the disease, or o	omplications that cause	ed the death.									Approximate	
	Enysician		Immediate Cause (Final	_	Man.									Interval Between Onset and Death	
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	Examiner		Sequentially list conditions	b. Due to (or a			Conte	200	nha	Dos	ne				
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	and end I-trans	Examine	that initiated events resulting in death) Last	c. Due to for a	s a conseque	ence of):									
8760,	death certificate be executed e attending physician and of for use as the burial-transit				5 u 501155qui	onos ory.									
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Вох	death certifical attending place as the for use as the state of the state as the state of the st	M/U	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom								23d. Da	te of deliv	very	
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Ś	es ign	by	Part II. Other significant condition	/	, ,			_ "	n in Part I.					the cause of death?	
Record	v requires been sign should be	Completed	Charai Hada	Diene	. De	1100	1	,	~		1 □ Ye	os 2.22rNo ————	3    Pro	bably 4 Unknown	
ec Sec	2 5 8	nple	Committee 10020g	D'sene	· del	who	re lil	Les s			24a. Was a autops	y I	orior to co	opsy findings available ompletion of cause of	
a F	Th ate pag		while author	no Disess	n.						perform 1 Yes 2		death?	2 No	
Vital		o Be	25. Was case referred to medical examiner?	Hospital:				Othe	r.		(Check only on				
of		F	1 ☐ Yes 2 🛣 No 27. Manner of Death	1 □ Inpat 28a. Date of Inj	ury 2	R/Outpatien 28b. Time of		c. Injury	4 Nul	-	ne 5 Reside			ify)	
lon	Attending For death.  sctor: After by the funer.	atlor	1 Natural 5 Pending 2 Accident investiga	(Month, Di	ay Year)	Injury	М	Work	? es 2 □ N			. ,			
Division	l or Attendii after death. Director: A in by the fu	ifica	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		njury - At hon	ne, farm, stre	et, factory,	office		2			er or Rui	ral Route Number,	
Ö	tal or A s after el Dire ed in by	Certification;	Tromicide	building, e	яс. (Зреспу)						City or Towr	i, State)			
	To the Hospital or At within 24 hours after of To the Funerel Direct completely filled in by	edical	(Check only 2 Medicel E	Physicien: To the bes xaminer: On the basis	t of my know of examination	ledge, death	occurred a	t the time	e, date and	d place, a	and due to the ca	ause(s) and ma	nner as	stated. to the cause(s)	
	thin 24 thin 24 the F	Medi	one) 29b. Signature and title of certifier	and manner s	tated.			License							
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	И		30. Name and address of person R	STrol 4	25 h	Lelen	Ca	1 /2	rlei	000	mm	lle a	<b>0</b> 5	12r	
	Sta	te	24 Date filed (Month Day Veer)	20 Desire	Landa Cimana.										
	Registr	ar	NOV 2 2 201	05 Beach	J.	Append									

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		Unpend ite  1 - State Registrar	State of	Marylar		artmen rtificat			ind Me		giene Reg. No.	JUJ	37	64	3
ÿt:		1. Decedent's Name (First, Middle, Last)  2. Date of Death  3. T										Time of C	Death		
Physicia /Medic		Cortni Shariko Ricks November 11									.1, 2Ö	Ö5 06	640	АМ	
Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death													
	e .	University Hospi				If the de		timore							
Funeral Director		216-73-6230	1. Sex 7. 1 □ M 2 1 F	Age (In yrs.	/ast birthday) Yrs.	Months 2	Days 25	If Under 2 Hours	Min.	8. Date of Bir (Month, Da 08–25–20	th y, Ye <i>ar)</i> 005		Birthplace ( Country) ryland	State or	Foreign
and W	To Be Completed by Funeral Director	Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ty, Town or Lo	cation				10d. Inside City Limits					
the Marylar 28a-f ehow notified at			NTA.		,,		•					1 X Yes 2 ☐ No			, –
28a-1		MD 10e. Street and Number	NA			Balt 10f. Zip	imore				10a Citi	zen of What	Country?		
th with 23a or		532 Payson Street 21217									rog. O.		Country		
								in? (Spec	USA (Specify Yes or No- 14. Race - American Indian,						
rs after dea I', or Iteme		1 XNever Married 2 Marrie 3 Widowed 4 Divorced	Armed Force	1 ☐Yes 2 🕅 No			Was Decedent of Hispanic Origin? (Specify Yes or f Yes, specify Cuban, Mexican, Puerto Rican, etc.)  □ Yes 2▼ No Specify:				Black, White, etc.  Specify:				
"natural",		15. Decedent's Education 16a. Decedent's Usual Occupation						-	Black						
in 72		(Specify only highest grade completed) (Give kind of work done during most of wo						of workin	king						
iene.		Elementary/Secondary (0-12) NA	College (1-4	or 5+)	1	NA.				NA					
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ould be i Mental I arked o atic eve		Corey Antonio Rick	S					S	halon:	ni Demiko Petty					
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lith an 27 is r trau		Maritez Rodriquez- M	kKenzie /gra	ndmothe	r 532 I	Dayson	Stroc	t Rolt	imons	MD 212	17				
of Health of Health I Item 27 I	-	20a. Method of Disposition		20b. F	Place of Dispo	sition (Nai	me of		Da			cation - City	or Town, S	tate	
ages anf of tt: If If		1		975	Zion Ce	-		.	1-22-0	25	Το	nsdowne	MD		
permit. Pages Department of Important: If I any Injury or one		21. Signature of Funeral Service Li		110.		·		s of Facility		,	Lici	TISCOWITE	, rio		
permi Depar Impor any Ir		Man	Tana					•		638 N.G	ilmor	Street	Balto.	. MD	21206
Fnysician /Medical	Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and Death disease or condition resulting in death)  Sudden Infant Death Syndrome (SIDS)  Due to (or as a consequence of):													
be executed sicien and purial-transit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C. Due to (or as a consequence of):													
ate be ex hysicien the buria	cai	,	d												
death certific e ettending p id for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 ments? 1 ☐ Yes 2 ☐ No. 9 ☐ Unknown	23c. If yes, outcome of pregnancy  1  Live birth 2  Fetal death 3  Ectopic pregnancy  4  Pregnant at time of death 5  Other (specify)						2	23d. Date of delivery Month Day Year					
that the deed by the detached	님	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did t	bbacco use contribute to the cause of death?				
wrequires that the been signed by th should be detache	ted by										1 ☐ Yes 2 D √ 0 3 ☐ Probably 4 ☐ Unknown				
The law ete has b page 2 st	Completed									24a. Was autor perfo	autopsy prior to completion of cause of design and performed?			vailable use of	
ysician: Th is certificete director, pag	Be (	25. Was case referred to medical examiner?						26. Place	of Death	Check only o	пе)	-			
Q 50	인	XXYes 2 □ No	Hospital: 1 ☐ Inpatient 2 ☐ FR/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Hom					me 5 Residence 6 Other (Specify)							
after Ine		27. Manner of Death  1 XNatural 5 Pending 2 Accident Investiga		Injury Day Year)	28b. Time o Injury	M	28c. Injury Work 1 🗀 `	at ? /es 2 🗆 N		28d. Describe how injury occurred					
affer des Directo	Certification:	3 Suicide 4 Homicide  6 Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							28	28f. Location (Street and Number or Rural Route Number, City or Town, State)					
To the Hospital or Attendi within 24 hours after deeth. To the Funeral Director: A completely filled in by the fu	Medical C														
ompl	Me	29b. Signature and title of certifier	and married classes							29d. Date signed (Month, Day, Year)					
0								O.C.M.E. No				vember 12, 2005			
		, 0.12	reenber	9 M.i	٥,		11 Pe	enn St	treet	Balt	imor	e, Ma	ry1and	1 212	201
Sta	te	31. Date filed (Month, Day, Year) NOV 2 2 2		istrar's Sign	ature	4.									

Box 68760. Records, P.O. ゴ 0 V2 Division

Baltimore, Maryland 2121

JOVEMBER

Vital Hospital or Attending Physician: ō this After To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun

					1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Minknown					
					24a. Was an autopsy performed? 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No					
25. Was case referred to medical	26. Place of Death (Check only one)									
examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	DOA	Home 5 ☐ Residence 6 Dother (Specify) Hospici						
27. Manner of Death  Natural 5 Pending 2 Accident investigation		28b. Time of Injury M	28c.	Injury at Work? 1 Tes 2 No	28d. Describe how injury occurred					
3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, street, fa	ctory, of	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
On Carting Statements	vericiem. To the best of an in-	audadaa daab aaa.		bo time data and also						

(Check only one)

29b. Signature and title of certifier

Certification: To

Medical

29c. License number 43721

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) November 19, 2005

Valley Rd, Timonum, Md

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dulaney DR TARIQ 2300 MAHMOOD

31. Date filed (Month, Day, Year) State NOV 2 2 2005 Registrar's Signature

Registrar

			_ FOI	partment of Health and Me ertificate of Death	ntal Hygien	0000	7645
	Physici	an	1. Decedent's Name (First, Middle, Last)	S = 1 = 1 = 1/	Date of Death	ay Yeer 8 2005	3. Time of Death
	/Medic Examin Funeral Director	er	4a. Facility Name (If not institution, give street and number)  8036 SOILEY KOOD  5. Social Security Number  6. Sex  7. Age (In yrs. last birthdown)  Yrs	4b. City, Town, or Location of Death  Orlen  Burnie  ay) If Under 1 Year If Under 24 Hrs. 8  Months Days Hours Min	Date of Birth (Month, Day, Year	c. County of Death  ANNE ARUN  9, Birthpla	DEL COUNTS ace (State or Foreign or)
	Maryland -f show	tor	Usuel Residence of Decedent  10a. State  10b. County  10c. City, Town or	Location  GIED SUR	NIE	10	od. Inside City Limits 1 ☐ Yes 2 1 No
	with the	i Director	10e. Styleet and Number	10f. Zip Code 21060	10g. C	itizen of What Count	ry?
036	filed within 72 hours after death with the Maryland Hygiene ither than "natural", or Items 23a or 28a-1 show ither than "natural", or Items reset the trutified at ont, the Medical Examinat reset to this of a	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces? 12. Yes 2 No If Yes, Give Year or Dates:	3. Was Decedent of Hispanic Origin? (Specifi Yes, specify Cuban, Mexican, Puerto Ric  1 Yes 2 No Specify:	ry Yes or No- can, etc.)	14. Race - America Black, White, e	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene important: if Item 27 is marked other than "natural", if many or other traumatic event, Ita Medical Eva any filery or other traumatic event, Ita Medical Eva 2010.8.	Completed	(Specify only highest grade completed) (G	ocedent's Usual Occupation live kind of work done during most of working b. DO NOT use retired)		Kind of Business/Indi	ustry Oo.
yland 2	2 should be filed and Mental Hyg is marked other aumatic event,	To Be C	17. Father's Name (First, Middle, Last)  WILLIAM H, SEA	3WICK RILL	A	How	ARD
	is 1 and 2 sh of Health and Item 27 is m other traum		SHERRY A. SEDGWICK GRAND-DAUGHTEN 80 20a. Method of Disposition 20b. Place of Disposition	ailing Address (Street and Number or Rural F sposition (Name of Date of Communication of Co	EN BURN	Cor Town, State, Zip of Location - City or Tow	21060
Baltimore,	permit. Page Department of Important: If any Injury or once.		12 Burial 2 Cremation 3 Hemoval from State  14 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee	5 VILLE CEME. 11-22 22. Name and Address of Facility 2140	N. Fu Hon F Uneral Ho	11 . 11	= MD. 2/2/7 more MD
8760, <	Physician / Medical Examine pringing and physician and physician and physician and the pringing and physician and	ai Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac or r	espiratory arrest,		Approximate Interval Between Onset and Death
9	cate chy the	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   Unknown   Unknown   Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of deliver Month	y Day Year
rds, P.	quires that the signed by and be detacted	ed by Ph	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobacco	use contribute to the	
Il Reco	: The law recate has bee	Completed			24a. Was an autopsy performed?	prior to com death?	sy findings available apletion of cause of
f Vita	iysiclan: Th iis certificate director, pag	To Be	25. Was case referred to medical examiner? 1	26. Place of Death (4 tient 3 DOA Other: 4 Nursing Home	. /	6 □Other (Specify,	)
Division of Vital Records, P.O. Box	To the Hospital or Attending Physician: The law requires that the death certifumin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending I completely filled in by the funeral director, page 2 should be detached for use as	Medical Certification;	27. Manner of Death  1 Natural 2 Accident 3 Suicide 4 Homicide  28. Date of Injury (Month, Day Year) investigation 28. Place of Injury - At home, farm building, etc. (Specify)	ry Work? M 1 ☐ Yes 2 ☐ No	d. Describe how inj f. Location (Street a City or Town, Sta	and Number or Rural	Route Number,
Ω	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fo	icai Cel	29a. Certifier (Check only (Ch	eath occurred at the time, date and place, and rivestigation, in my opinion, death occurred	d due to the cause( at the time, date a	s) and manner as stand	ated. the cause(s)
	Fo the Mithin 24	Medi	one) and manner stated.  29b. Signature and title of certifier	29c. License number		ate signed (Month, E	
			Manual Mp A	PhD. D50498	No	vember 1	8,2005
	31		30. Name and address of person who completed cause of death (Item 23a) (Ty  Maura LE, Ilison Johns Ho	pe, Print) pKins Huspita	Q		
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) 22. Registrar's Signature	ph. D50498 pe, Print) pKins Huspital			

State of Maryland / Department of Health and Mental Hygiene 🕦 🕦 5 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 11/15/2005 **Physician** 1:45 PM Michael Edward Seidler, Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel 1307 Odenton Road Odenton If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 12/06/1938 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 🔀 M 2 🗆 F Yrs. 212-36-7835 66 MD Director Usual Residence of Decedent deeth with the Maryland 10d. Inside City Limits 10c. City, Town or Location ehow. 10b. County r then "natural, or items 23a or 28a-f ehover the Medical Examinar must be notified at 1 ☐ Yes 2 X No Director MD Anne Arundel Odenton 10g, Citizen of What Country? 10e, Street and Number 10f. Zip Code 1307 Odenton Road 21113 U.S.A. Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 XYes 2 No 1971 · If Yes, Give Year or Dates: 1977 e filed within 72 hours after al Hygiene "natural", or Ite 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry U.S. Navy/ Petty Ofcr/ Elementary/Secondary (0-12) College (1-4or 5+) 12 Commercial A/C Electrical Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) t 1 and 2 should be fill Health and Mental H tem 27 le marked oth Alva Martha Brannock Adam Victor Seidler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tina Carr / Daughter 645 Kingston Road, Middle River, MD 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Depertment of H
Important: If Itel
any injury or ott 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/21/05 Crownsville, MD MD Veterans Cem 22. Name and Address of Facility G.J.Gonce Funeral Home, 21. Signature of Funeral Service Licensee 169 Riviera Drive, Pasadena, MD 21122 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires thet the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month 4☐Pregnant at time of death 5 Other (specify) been signed by the s should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 □Unknown 1 Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) After thi 27. Mannet of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pendina s after death.
I Director: Aft
id in by the fur 1 ☐ Yes 2 ☐ No М 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) techeter DICESAM LEGRARIO 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2005

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar			ate of	Maryla					and M		Reg. No.	005	37	647
	Physici	an					_						2. Date of De Month		Ye	ar	Time of Death
	/Medic	al							45 Cib. 3	Faur	Location	4 Death	Novemb				126 hrs".
	Examin	er				t and numi	o⊕r)					or Death					.1
	Funeral				6. Sex		. Age (In yrs	s. last birthday)	If Under	1 Year	If Under		8. Date of Bi	th		Birthplace (	(State or Foreign
	Director		The content share prints Mode, Land   Sanders   Substitution   S		Maryla	and											
	and						10c. C	City, Town or Lo	ocation							10d. in	nside City Limits
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36	rs afte	oy Fi		_	1 11	Yes, Give			1 □ Yes 2	No 🚅	Specify:				Specify: W	hite	
21215-0036	e filed within 72 hours after death with the Maryland at Hygiene. other then "neturel", or lieme 23a or 28e-1 show went, the Maulical Examinar must be multified at	ted		15. Deceder	t's Education	n		16a. Dece	dent's Usua	I Occupa	ation			16b. Ki	nd of Busine	ess/Industry	/
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and	Mental H Mental H arked oth etic even	Be													Sumame)		
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<u>E</u>	Pages nent of ent: If it ury or o					val from St	Lo			,		1/21	/2005	Malt	imore	, MD.	
Balt	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel; or lieme 23a or 28e-1 show amy injury or other treumetic event, the Madical Examinac must be multified at ance.		21. Signature Fu	neral Service	Licensee	0		22 <b>LI</b>	2. Name and	Addres	s of Facilit	У	o Tna	410	7 Wil	kens .	Ave.
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			shock, or hear	rt failure. List	only one ca	use on eac	ch line.	_			_	cardiac c	r respiratory a	rrest,		Inter	roximate val Between et and Death
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	Registr	-		NOV 2	2 2005		Acres 1	M. K.	Carle	,				_			

Amend Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 5 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** Year FREDERICK L. STAFFORD November 17. 2005 10:44 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner St. ACINES HEALTH CARE BALTIMORE NA If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth (Month, Day, Year) 09 - 05 - 1934 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1**⊠**M 2□F 217.34.9762 Yrs. Director 71 mo Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or 28a-f show NA 1 Yes 2 No MD BALTIMORE Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? STREET 3612 EVERSLEY 21229 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 "natural", or 1 Yes 2 No Specify: þ Specify: BLACK 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) FOOD SERVICE 12 TH GRADE YRS SALESMAN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (WIFE) item 27 ST. BALTIMORE QUEEN E. STAFFORD 3612 EVERSLEY MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 11/22705 permit. Pages 1 Department of P Important: If ite any injury or ot once. 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 11-64-05 GREENMOUNT BALTIMORE, MD <sup>¹</sup> 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility VAUGHN C. GREENE FUNERAL SERVICE 21. Signature of Funeral Service Licensee 23a. Part1. Enter w disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MULTILOBAR PNEUMON IA. **Physician** days /Medical Due to (or as a consequence of): **Examiner** COLLAPSE. LEFT LUNC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence or) Examine The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Year 4□Pregnant at time of death Month Day 5 ☐ Other (specify) o 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, MULTIPLE SCELROSIS. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 DV or Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Hospital: 1 Dinpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) After thi 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No Diractor: / 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or At within 24 hours after or To the Funeral Dirac completely filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P-18613-MUHAMMAD SAIM, M.D. November, 17,2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAIM, M.D 9005- Caton Ave. BALTIMORE, MD-21229 MUHAMMAD 31. Date filed (Month, Day, Year) 32. Sgistrar's Signature State

Registrar

NOV 2 2 2005

Stafford, Frederick

			1 - For Amend Item	8 State of M	832,02/289	ortment of H	lealth an D <i>eath</i>		giene 05	37649
164 1			1. Decedent's Name (First, Middle, La	ast)		· · · · · · · · · · · · · · · · · · ·		2. Date of Dea	ath	3. Time of Death
- 20	Physic /Medi		Joseph P. Steu	ernagle				Novem	ber 192	Year 00'5 4:30 A™
	Examir		4a. Facility Name (If not institution, gir	ve street and number)	,	4b. City, Town, or		Death	4c. County of	of Death
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	Funeral Director		215-70-3593	1 XM 2 F	e (In yrs. last birthday) 49 Yrs.	Months Days		Min. 8. Date of Birt (Month, Date 2	5,1956	Birthplace (State or Foreign Country)     MD
	land		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	ocation			<del></del>	10d. Inside City Limits
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	ema ema	Iner	11. Marital Status	12. Was Decedent Armed Forces?		Was Decedent of H	spanic Origin	? (Specify Yes or No-	14. Race	- American Indian, White, etc.
21215-0036	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If item 27 is marked other than "natural", or itema 23a or 28a-1 show or other traumatic event, the Medical Examinational Legisling at	t by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 TYPes 2 1 If Yes, Give Year or Dates:	No	1 ☐ Yes 2 ☐ <b>X</b> No	Specify:		1	White
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	filled whygie ther ther int,		10th 17. Father's Name (First, Middle, Las.	t)		Mechanic	18. Mother's	Name (First, Middle,		omotive
Maryland	buld be filed with Mental Hygiene arked other than atic event, the	To Be	John H. Steuern				Marga	ret E. Her	vring	
	1 and 2 should Health and Mer em 27 is marke ther traumatic		19a. Informant's Name/Relationship Ginger A. Steue			ng Address (Street a Caledonia	and Number o	r Rural Route Numbe Lansdowne	r, City or Town, S	itate, Zip Code) 21227
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr pnca.		20a. Method of Disposition  1 Burial 2 Cremation 3 [ 4 Donation 5 Other (Speci		20b. Place of Disponsion Place of Disponsion Commetery, cres	natory or other plac	e) 11	Date - 22 - 05	20c. Location - C Baltimo	City or Town, State
Balti	permit. Pages Department of Important: if it any injury or c		21. Signature of Funeral Service Lice	•	22	2. Name and Address	s of Facility	Schimunek	Funeral	Homes
N. S. S. S. S. S. S. S. S. S. S. S. S. S.	3.		23a. Part1. Enter too disease, or con	aplications that caused	the death. Do not ent	331 Brehm er the mode of dyin	S Lane g, such as car	, Baltimor	Le, Md.	Approximate
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8760,	cate be execufed physician and the burial-transit	dicai	that initiated events ' resulting in death) Last	c. Due to (or as	a consequence of):					
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DIVISION	if or Attending after death. Director: After din by the fune.	Certification:	3 Suicide 6 Could not be determined	OB Class of Init	ury - At home, farm, str c. (Specify)			28f. Location (Si City or Town		or Rural Route Number,
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	vithii To th	M	29b. Signature and title of certifier			29c. License	number	2	9d. Date signed	(Month, Day, Year)
	1.61		30. Name and address of person who	completed cause of d	indula phys	ich Do	006150	64	11-19	7-05
1500	671		31. Date filed (Month, Day, Year)	Howard	900	Caton A	ve.	Baltimor	e, MD	2/229
***	Sta Registr	_		2 2005 D	ar's Signature	Court	,			

Stevernagle. Joseph P

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) Physician 18:42 PM Gladys M. Simmons /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner cred Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, 9. Firthplace (State or Foreign **Funeral** Days Hours Min Months 1 ☐ M 2 🗶 F 75 Yrs. 19,1930 Westernport, MD Director 232-54-4371 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or Items 23s or 28s-f shov the Medical Examinar must be notified at 1 ☐ Yes 2 No Director **Allegany** Westernport 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Rt. 1, Box 39 21562 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: þ 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade com 16b. Kind of Business/Industry completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 9 Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 12 should be f h and Mental H Joseph R. Ahern Eva Mae Butts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 at Department of Health at Important: If Item 27 is any injury or other trau Marguerite Likin/ Sister Rt. 4, Box 179 Keyser, WV 26726 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Nov. 18 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Zion Cemetery 2005 Augusta, WV 21. Signature of Euneral Service Licensee 22. Name and Address of Facility Smith Funeral Home Busin 0 85 S. Main Street Keyser, WV 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Sep 875 2 hours /Medical Due to (or as a consequence of): Examiner Tract Infection Um Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examine led by the attending physician and detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Year Month Dav 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? arten 1 🗌 Yes 2 🗆 No 1 Yes 20 No To the Hospital or Attending Physician: the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Hnpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death After 1 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Matural death. 1 ☐ Yes 2 ☐ No 2 Accident after death 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D21244 11/15/05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Route#36 FROSTBURG, MD DA. Jesus Tan 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2 2 2005 Registrar

			riease	State of Ma						-	_		
		•	For State Registrar	Otato or ma	i y taria /		ificate of L				.2.0 (	)5	37651
	作者 黃藤		Decedent's Name (First, Middle, Las	t)			····		2.	Date of Deat Month	h	Year	3. Time of Death
	Physici /Medic		Amelia M. Smit	h						11	Day 21	2005	12:30 AM
	Examin		4a. Facility Name (If not institution, give	street and number)		4	4b. City, Town, or	Location o	of Death		4c. Coun	ity of Death	1
		36-17	13324 Fork Road	7.40	(In our last hi	inth day)	Baldwi If Under 1 Year	n If Under a	24 Hrs o	Date of Birth		timor	
	Funeral Director		5. Social Security Number 6. So	ox 7. Age □M 2√F 7. Age	(In yrs. last bi		Months Days	Hours	Min.	(Month, Day, 5/06/1)	Year)		place (State or Foreign intry)
24	AT A		217-09-6964 Usual Residence of Decedent							3/00/1	917	l'Id	ryland
	death with the Maryland me 23a or 28e-f ehow	_	10a. State 10b. County		10c. City, Tov	vn or Loca	ition						10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	i within 72 hours atter death with the Marylar jiene, rithen "natural", or Itame 23a or 28e-f ehow the Mautcal Examment must be putified at	Director	MD Baltimo	ore	Bald	lwin	101 7in Code			1	0g. Citizen o	( What Car	
	a or 2	Dİ	10e. Street and Number				10f. Zip Code						antry :
	ne 23	Funeral	13324 Fork Road  11. Marital Status	12. Was Decedent E	ver in U.S.	13. Wa	21013 as Decedent of Hi res, specify Cuba		gin? (Specif	y Yes or No-		ace - Amer	ican Indian,
	or Itan		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 X N If Yes, Give	0		res, specify Cuba ⊇Yes 2[X]No	in, Mexican Specify:	i, Puerto Hic	an, etc.)		lack, White	, etc.
9500-61212	hours after tural', or Ita	d by	3 X Widowed 4 □ Divorced	Year or Dates:							Spec	Whi	
2	"nati	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a	a. Deceder (Give kır life DC	nt's Usual Occupa nd of work done of NOT use retired	ation during most	t of working		16b. Kind of	Business/li	ndustry
Z	filed within 72 Hygiene. sther then "natent, the Wadion	ф	Elementary/Secondary (0-12)	College (1-4or 5	+)		maker	7		COLUMN TO THE CO	Otazo	Home	
	T Tay	0	17. Father's Name (First, Middle, Last)			ПОПС	liaver	18. Mothe	er's Name (F	irst, Middle, I			
<u> </u>	uld be Mental Irked c	To B	John Huber					Mar	garet	Frank			
Maryland	2 should and Men le marke eumatic		19a. Informant's Name/Relationship (7	Type, Print)	19	b. Mailing	Address (Street a	and Numbe	er or Rural F	loute Number	, City or Tow	m, State, Z	ip Code)
700	f Health Item 27 other tr		Lynda Jones (dai	ıghter)	20h Place	530	Lee S M	ill R	load -		tead, 20c. Location		
Baltimore,	00		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □	Removal from State	cemete	ery, crema	itory or other plac	1					
			4 Donation 5 Other (Specify 21. Signature of Funeral Service Licen		St. Jo	ohn C	Church Ce	em	11/23/	2005 H	lydes,	Mary.	land
g	permit. Departi Importi any inj		· C. A. L.	0.0		117	750 Bola	ir Ro	'Е. F ad – Ж	. Lassa Cinasvi	ahn Fu lla N	neral Marvl:	Home, P.A. and 21087
9			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused	the death. Do							HIL Y IC	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	2010 cause on each m	o. C=2+)	0.	BREAS	-0	a ace	10			Onset and Death
	/Medical		resulting in death)	Due to (or as	consequence	of):	Dreas		700				(2) 11/12
	Examiner		Sequentially list conditions,	b									
/	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence	9 Of):							
	be executed icien and burial-transit	xan	that initiated events resulting in death) Last	c Due to (or as a	consequence	e of):							
760	m 0 m	caiE		d									
	leath certificate ettending phy I for use as the			W									
Вох	The law requires that the death certifica ate has been signed by the ettending ph page 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 Live birth		th 3□E	ctopic pregnancy	,				Date of delin	very Day Year
о. Е	e dea the ett	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of death	5 🗆 0	Other (specify)				ľ	violitii	Day
<u>п</u>	w requires that the de been signed by the should be detached	Phy	Part II. Other significant conditions of	ontributing to death by	ıt not resultina	in the und	deriving cause give	en in Part I.		23e. Did to	bacco use co	ontribute to	the cause of death?
Records,	signe d be o	d by	, a.,		······································		,g g			1 🗆 Ye			obably 4 []Unknown
Sor	w requ	Completed								24a. Was a	n 24t	o. Were au	topsy findings available
Re	he la e has age 2	ошо								autops	med?	prior to c death?	completion of cause of
Vital	en: 7 tifical tor, p	0	25. Was case referred to medical		<del></del>			26. Place	of Death (6	1 ☐ Yes	2 <b>A</b> No	10103	20110
<u>_</u>	Physicien: The lav this certificate has al director, page 2	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatie	nt 2 ER/C	outpatient	3□ DOA Oth	er: 4 □ Nu	ursing Home	5 Reside	ence 6 □C	ther (Spec	ufy)
0	ng Ph		27. Manner of Death  1   Natural 5 □ Pending	28a. Date of Injur (Month, Day	y Year) 28b.	Time of Injury	28c. Injun Wor	k?		d. Describe ho	ow injury occ	urred	
<u>s</u>	ttendi death tor: /	cati	2 Accident investigation 3 Suicide 6 Could not b	9 290 Place of Inju	in. At home	form stree		Yes 2		Location (S	treet and Nu	mhar or Ru	ral Route Number,
Division of	after after Direction by	Certification:	4 ☐ Homicide determined	building, etc		iaiiii, stiee	et, factory, office		201	City or Town		TIDOT OF TIE	rai i ibate Namber,
_	spite		29a. Certifier 12 Certifying Pt	ysician: To the best	of my knowledg	ge, death o	occurred at the tir	ne, date an	nd place, and	d due to the c	ause(s) and	manner as	stated.
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,	Medical	(Check only 2 Medical Exar	niner: On the basis of and manner sta		and/or inve	estigation, in my o	pinion, dea	ath occurred	at the time, d	late and plac	e, and due	to the cause(s)
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Σ	29b. Signature and title of certifier		11		29c. Licens	e number	- /	2	9d. Date sign	ned (Month	n, Day, Year)
}	0		Manhael	low for	1		23	223			11/2	10	
	20		30. Name and address of person who	completed cause of d	eath (Item 23a	(Type, P	rint) Ro	H.	314	Bol	time	ul	21237
1	V St	ate	31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	- 1/11			/				
	Regist	1101.0 9 2005											

			1 - For State Registrar	State of M	laryland / Depa <i>Ce</i>	artment of H			iene 1005	37652
*	Physici	an	1. Decedent's Name (First, Middle, Last			•		2. Date of Deatl	Day Yes	3. Time of Death
	/Medic		Nina C.						, 2005	9:30 A M
	Examir	ier	4a. Facility Name (If not institution, give Oak Crest Care Ce		)	4b. City, Town, or	r Location of L arkvill		4c. County of D	oath Simore
	Funeral		5. Social Security Number 6. Se	x . 7. A	ge (In yrs. last birthday)	If Under 1 Year	If Under 24	Hrs. 8 Date of Birth	9	Birtholace (State or Foreign
765	Director		200-07-0720	]M 2 <b>∑</b> F	95 Yrs.	Months Days	Hours	Min. Aug. 22,	1910	On i o
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	Maryl -f ehc	to	Md. Balt	imore		Park	ville			1 ☐ Yes 2 🖔 No
	or 28e	lrec	10e. Street and Number			10f. Zip Code		10	og. Citizen of What	Country?
	ath wi	rai	8820 Walther Blv	<u>-</u>	4122		21234		Ę	JSA
	72 hours after death with the Maryland natural; or items 23a or 28a-f ehow disal Examinar must be redified at	Completed by Funeral Director	11. Marital Status	12. Was Deceden: Armed Forces 1 ☐ Yes 2 ♠	?	Was Decedent of H If Yes, specify Cuba	ispanic Origin ın, Mexican, F	n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - A Black, W	merican Indian, Ihite, etc.
36	urs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 <b>XXX</b> No	Specify:		Specify:	White
21215-0036	72 ho	eted	15. Decedent's Edu (Specify only highest grad	cation e completed)	16a. Dece	dent's Usual Occupa	ation	f working	16b. Kind of Busine	
2	within ene. then "	m ple	Elementary/Secondary (0-12)	College (1-4or	5+) life.	kind of work done of DO NOT use retired		, working		
	filed v Hygie other t		17. Father's Name (First, Middle, Last)	Т		Homema		Name (First, Middle, M	Own H	lome
Maryland	should be f and Mental h marked of umatic eve	To Be	Simon	Coleman				Margaret	Hanthorn	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants if Item 27 is marked other then "natural", or Items 23a or 28a-f ehow arry injury or other traumatic event, the Medical Examinar must be notified at any injury or other traumatic event, the Medical Examinar must be notified at any injury or other traumatic.		19a. Informant's Name/Relationship (T) Mrs. Nina S. Davis			ng Address <i>(Street a</i> Fork Roa		or Rural Route Number. Aldwin, Mary		
Baltimore,	es 1 a of Hea fitem r othe	i ii	20a. Method of Disposition	lamaual from Chair	20b. Place of Dispo	sition (Name of matory or other plac	re)	Date 2	20c. Location - City	or Town, State
Ë	Pages ment of ant: if it	١.,	1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	State	Hilltop S	ervice Co	prp. 11		owson, Ma	
Balt	permit. Departr Importu eny inju		21. Signature of Funeral Service Licens	1 Ru	8/1	050 York	Road	Towson, Mai	ryland, 2	Home, Inc. 21204
			23a. Part1. Enter the disease, or compleshock, or heart failure. List only of	ications that cause ne cause on each	d the death. Do not ent line.	er the mode of dyin	g, such as ca	rdiac or respiratory arre	st,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Bla	Dov con u	/				Months
A.	Examiner			Due to (or as	s a consequence of);					
64		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	s a sunsequence of).		_			
	ecuted and transi	Examiner		o						
8760,	icate be executed physician and s the burial-transit	E E	resulting in death) Last	Due to (or as	s a consequence of):					
687	icate physics sthe	edical		i						
Box (	eath certific attending p	N/M	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome		_			23d. Date of	delivery
. B	ne death the atte	Physician/Me	in the past 12 months? 1 □ Yes 2 No			Ectopic pregnancy Other (specify)			Month	Day Year
P.O.	that the ded by the detached	Phy	9 ☐ Unknown  Part II. Dther significant conditions con		but not condition in the co		- i- D I	22a Didash		to the cause of death?
Records,	The law requires that the death certificate be executed tee has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	ted by	Tatti. Ditter significant contantons con	Timbuting to death	out not resulting in the u	ndenying cause give	en in Part I.			Probably 4 Unknown
Reco	The law rate has be page 2 sh	Completed						24a. Was an autopsy perform	prior t	autopsy findings available to completion of cause of
		e Co	25. Was case referred to medical				26 Place of		No 1□Y	es 2 No
ΓV	Physiclan: this certificatal director.	To B	examiner?	lospital:	ient 2 ER/Outpatier	it 3□ DOA Othe	r: /	ng Home 5 ☐ Resider		pecify)
			27. Man of eath  Natural 5 ☐ Pending	28a. Date of Inj (Month, Da	ury 28b. Time of Injury	28c. Injury Work	at	28d. Describe how		
Sio	Attendia death. ctor: A y the fu	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be				Yes 2 □ No			
Division	al or Attency safter death If Director: of in by the	Certification:	4 Homicide determined	28e, Place of In building, e	jury - At home, farm, str tc. <i>(Specify)</i>	eet, factory, office		28f. Location (Str. City or Town,	eet and Number or State)	Rural Route Number,
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	Medical	29a. Certifier Certifying Phy (Check only one)	sician: To the best ner: On the basis of and manner s	of my knowledge, death of examination and/or in- tated.	vestigation, in my op	na data and p pinion, death o	vane and die to the cau occurred at the time, da	use(t) and it anner te and place, and d	as stated lue to the cause(s)
	To th viithir To th comp	Me	29b. Signature and title of certifier	7 20		29c. License		29	d. Date signed (Mo	onth, Day, Year)
	N		• / /	و المالية		053	311		Voice-Le 1	7th 2005
(	2		30. Name and address of person who co	empleted cause of			nu	Prkulle	3-0	222
	Sta	te	31. Date filed (Month, Day, Year)	32. Regist		hall	100	110000	C EYVO 4	1436
	Registr		MOV 2. 2	2005	rar's Signature	Smalle				

	1	1 - For State of Maryland / Dep Registrar Ce	artment of Health and I rtificate of Death	Mental Hygie		37653
Physicia /Medica		1. Decedent's Name (First, Middle, Last) Paul Joseph Scheel, Sr.			17, 2005	3. Time of Death 10:30 p M
Examine		4a. Facility Name (If not institution, give street and number)  32 Oakridge Court  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	4b. City, Town, or Location of Death Lutherville  If Under 1 Year   If Under 24 Hrs.		4c. County of Dea Baltimore	
Funeral Director		216-30-5424	Months Days Hours Min.	Nov. 15,	1933 Ma	aryland
the Marylar 28a-f ehow	Director	Md. Baltimore 10c. City, Town or Lutherv:	ille		0	10d. Inside City Limits 1 ☐ Yes 2 ☑ No
th with		32 Oakridge Court	10f. Zip Code 21093	Tog.	Citizen of What Co USA	ountry?
urs a	by Fur	11. Marital Status  1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Amed Forces?  13. □ Was Decedent Ever in U.S. Amed Forces?  14. □ Was Decedent Ever in U.S. Amed Forces?  15. □ Was Decedent Ever in U.S. Amed Forces?  16. □ Was Decedent Ever in U.S. Amed Forces?  17. □ Was Decedent Ever in U.S. Amed Forces?  18. □ Was Decedent Ever in U.S. Amed Forces?	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 1 ☐ Yes 2 ☑ No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, White Specify:	
od within 72 h giene. er then "natu	Completed	(Specify only highest grade completed) (Give Elementary/Secondary (0-12) College (1-4or 5+)	Ident's Usual Occupation Is kind of work done during most of wor DO NOT use retired)  BTY/ Executive	king	. Kind of Business	/Industry
permit. Pages 1 and 2 should be filed within Depertment of Health and Mental Hygiene. Important: if item 27 is marked other then eny injury or other treumatic event, tire Mana.	To Be (	17. Father's Name (First, Middle, Last)  Joseph Scheel	Julia	ne (First, Middle, Maid Hintenacl	٠	
and 2 sh alth and 1.27 Is m			ing Address <i>(Street and Number or Ru</i> Dakridge Court Lut			. ,
ages 1 and of He		I Burial 2 Mcremation 3 Hemoval from State	matory or other place)		Location - City or	
permit. P Depertme Importan eny Injur.			Service Co. 11-2' <sup>2. Name and Address of Facility</sup> Ruck Towson Funer 1050 York Rd. Tow	al Home. I	nc.	Ma.
Physician /Medical		23a. Part1. Enter the disease, complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):	ter the mode of dying, such as cardiac	or respiratory arrest,	1204	Approximate Interval Between Onset and Death
rate be executed thysician and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseses or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):				
The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of de Month	livery Day Year
w requires that been signed by should be deta	2	Part II. Other significant conditions contributing to death but not resulting in the t	inderlying cause given in Part I.	23e. Did tobacc		o the cause of death?
	Completed			24a. Was an autopsy performed	prior to death?	utopsy findings available completion of cause of
hysicie this cert	ation: To Be	25. Was case referred to medical examiner?    Yes   25   No	nt 3□ DOA Other: 4□ Nursing H	th (Check only one) ome 5 Residence 28d. Describe how in	6 □Other (Spe	cify)
tel or Atters attended blinecto	Certificati	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Street City or Town, St.		ural Route Number,
To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medicai	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, deal 2 Medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place investigation, in my opinion, death occu	rred at the time, date a	and place, and due	o to the cause(s)
¥348		MialM-Fruellander, Mo	Manylord Das	8 673	Date signed (Mont	0
10/2		30. Name and address of person who completed cause of death (Item 23a) (Type, NEAL IN FAIEULANDEL, III.) + 100)	30. Charles St, Su	te 5105,	balto, 11	d 21204
Stat Registra		31. Date filed (Month, Day, Year)  32. Begistrar's Signature	books			

State of Maryland / Department of Health and Mental Hygiene ( State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1 Decedent's Name (First, Middle, Last) Month Year Physician P M November 18,2005 3:00 Smith Catherine /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Glen Burnie

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Sep. 24,1923 Anne Arundel 443 Rogers Avenue Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Funeral Months 1□M 2ÅF MD 82 217-12-2965 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits with the Maryland 10b Counts 10a. State or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director MD Anne Arundel Glen Burnie 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number 238 21061 USA 443 Rogers Avenue deeth Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 27 No If Yes, Give Year or Dates: filed within 72 hours after ٥ 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White Specify: ģ 34 Widowed 4 □ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Respiratory Therapist State of Maryland other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Deperment of Health and Mental Hy Important: if Item 27 is marked oth any injury or other treumatic event QDE8. Be Catherine Phillips Charles N. McBee ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 443 Rolers Avenue, Glen Burnie MD 21061 Mr. Mark B. Smith/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 25 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Nov 23 Chesapeake Cremation 2005 Stevensville, Maryland 22. Name and Address of Facility 21. Signatur of Funeral Servi Singleton Funeral Home, P.A. Second Avenue SW Glen Buenie MD 21061 23a. Partl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final TE **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours eiter death.

To the Funerel Director: After this certificate hes been signed by the attending physicien and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 Yes 2 Ho
9 Unknown ö 4☐Pregnant at time of death 5 Other (specify) signed by the at d be detached fo Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably → 100nknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificete hes t irector, page 2 s autopsy 1 ☐ Yes Division of Vital 26. Place of Death Check only one 25. Was case referred to medical Certification: To Be Other: 4 Nursing Home Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA After thi funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 5 Pending Maturai 2 No investigation 2 Accident Director: 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier In the desired of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

In the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier nuen 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 405 Frederick Md Site 162 I-ERNAWD ST ND 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

			For State Registrar	State of Maryland	d / Depa	artment of H	lealth and M	lental Hyg	ie2e0 0 5	37655
	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of Deat	n Dav Yes	3. Time of Death
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	Examin	er							4c. County of D	eath
-					st hirthday)			8 Date of Birth		
	Physician   No. Decoderin Name (First, Microse, Last)   Virginia M. Seal   Virginia M.									
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<u>ا</u>	72 ho	etec	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Deced	lent's Usual Occup	ation during most of work	ina	16b. Kind of Busine	ss/Industry
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_	shoul nd Ma mari	Ĕ			19b. Mailir	g Address (Street			City or Town, State	a. Zip Code)
2	alth a		Lester Seal, Sr.	Husband						
e G	s 1 a		·	20b. Pla	ace of Dispo	sition (Name of	(9:	Date 2		
Ē	Page nent c nnt: If			emoval from State Me	tro Cı	ematory	11/22	/2005 (	atonsvil	le, Maryland
baitimor	epartr epartr nports ny inju		21. Signature of Funeral Service License	° 4/	22 R	. Name and Addre	ss of Facility	Funeral	Uomo T-	- 21211
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			snock, or near failure. List only one	ations that caused the death. e cause on each line.	Do not ent	er the mode of dying	ig, such as cardiac o	or respiratory arre	st,	Interval Between
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			resulting in dealth)	Due to (or as a consequ	ence of):					
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o o	ath ce ttendi	an/I	23b. Was decedent pregnant 23			Ectopic pregnancy	,			,
j.	the a	/slcl	1 ☐ Yes 2 🗷 No		ath 5□	Other (specify)			Month	Day Year
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	To the Forth	Me	29b. Signature and title of certifier			29c. Licens	e number	29	d. Date signed (Mo	nth, Day, Year)
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	/		30. Name and address of person who con	npleted cause of death (Item	23а) (Туре,	Print)	* ** / 1 **	177	,,	
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			Registrar  1. Decedent's Name (First,	Middle, Last	1		06	Tunca	le oi Dei	alli	2. Date of Deat			3. Time of Death
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}	Examin	_	4a. Facility Name (If not ins.	iturion, give	street and num	91/1000	1201	4b City	Town, or Local	ation of Death	11/	4c. Count		th
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	Funeral Director		214-18-7225	1	]M 2 <b>⊠</b> F	83	Yrs.	Months	Days Ho	ours Min.		, 1922		
	and w		Usual Residence of Deceder 10a. State 10b. C			10c. Ci	ty, Town or L	ocation						10d. Inside City Limits
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	ges 1 and 2 should be filed within 72 hours after death with the Maryland at of Health and Mental Hygiene.  If the m 27 is marked othar than "natural," or Itams 23a or 28a-f show or othar traumatic event. It a Medical Examinational Convolition.	Funeral Director	10e. Street and Number 3939 Roland	Avenue	Apt. 5	20		10f. Z	p Code	1211	1	0g. Citizen of	What Co	ountry?
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2-0036	within 72 hours after ene. than "natural", or ite	ted b	15. De	cedent's Edu	cation		16a. Dece	dent's Us	ual Occupation			16b. Kind of E	Business.	/Industry
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ary	2 should be and Mentai is marked sumatic ev		19a. Informant's Name/Rel					_			I Route Number	*		
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Baitimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Fur eral Se			,								c. 21211
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X 68	leath certificate t attending physical for use as the t	/Med	IF FEMALE:	T	23c. if yes, outc	ome of predic	iancy					224 D	-44-	F
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Vital Records, F	The law requires that the death certificat ate has been signed by the attending phy page 2 should be detached for use as th	by	Part II. Other significant co	anditions co	ntributing to dea	ath but not re	sulting in the	underlying	cause given in	Part I.		oacco use cor es 2□No		o the cause of death?
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o	g Phy er this seral d	<b>!</b>	27. Manner of Death		28a. Date o		28b. Time		28c. Injury at Work?		28d. Describe ho			city)
Sior	Attending F death. ctor: After y the funer	catio	2 Accident	Pending investigation Could not be				M	1 🗆 Yes					
Division of	al or Attend after death I Director: d in by the f	Certification:		determined	289. Place	of Injury - At I g, etc. <i>(Spec</i>	nome, farm, s	treet, facto	ry, office		281. Location (St City or Town		Der or Hi	ural Route Number,
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	To the within To the comple	Med	29b. Signature and title of	ertifier				2	ec. License nui	mber DA	m 1 2	9d. Date sign	ed (Mont	th, Day, Year)
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	3		30. Name and address of	orson who	ompleted cause	of death (Ite	m 23a) (Type	Print)	and	Gene	ralL	nen!	tal	
19	Sta	ate	31. Date filed (Month, Day	Year)	320 Re	gistrar's Sign	ature &	Al y	MINI	4011	1011/	VY	M	
4.	Regist	rar	NOV 2	2 200	5	par A	The state of the s	No. of Lot						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Albert J. Stasiowski Nov 15 2005 04:00 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner St. Elizabeth Nursing Center Baltimore N/AIf Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** ty∏M 2∏ F 015-03-4053 97 Yrs Director May 15, 1908 Massachusetts Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or than "natural", or itema 23a or 28a-f show MD Baltimore 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5812 Heron Drive 21227 U.S.A. death 1 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes Z∑No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mentat Hygiene. Int: If item 27 is marked other than "natural", or ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: White þ 3℃Widowed 4 □ Divorced Completed 16b, Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Production Manager Westinghouse injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Frank Stasiowski Aniela Rypysz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) James M. Stasiowski/Son 5812 Heron Drive Baltimore MD 21227 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place)
Meadowridge Memorial
Park 1 M Burial 2 ☐ Cremation 3 Removal from State Department of Important: if an injury or one 11-18-2005 Elkridge, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licentee 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus MD 21227 anul 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. complications that caused the eath. Do not enter the mode of dving, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) neumomo day Physician G /Medical Examiner CINSON e ove Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner g physician and as the burial-transit The law requires that the death certificate be exec Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? for Month Dav Year 4☐ Pregnant at time of death 5 Other (specify) ate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 Yes 2 No 3 Probably 4 Linkshown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has 1 Yes 2 No 1 Yes 2 NO Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA 4⊟ Nursing Home 5 Residence 6 Other (Specify) funeral dir 28b. Time of 28c. Injury at Work? Certification: 27. Manner of Death 28d. Describe how injury occurred Injury 1 Natural 5 Pending after death.

I Director: Af in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a 1 🛨 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) omere NUR 31. Date filed (Month, Day, Year) 32 Registrar's Signature State NOV 2 2 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene. Amend Item #5 Per FH G850 12/06/09 rifficate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death Month Day Year November 18,2005 **Physician** GAYNOR CORONA STEWART 7:00AM /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Lutherville College Manor Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. Min. Months Deys Hours Min. March 1, 1919

8. Date of Birth (Month, Day, Year)

March 1, 1919 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2XX Months 109-18-7<del>272</del> 86 Yrs. Illinois Director Usual Residence of Decedent death with tha Maryland 10a. State 10b. County 10c. City, Town or Location if item 27 is marked other than "natural", or items 23a or 28a-1 show or other traumatic event, the Medical Examinat must be notified at 10d. Inside City Limits 1 ☐ Yes 2 ☐ X Directo Maryland | Baltimore Lutherville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 300 West Seminary Avenue 21093 USA Funerai 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes PA No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. parmit. Pages 1 and 2 should ba filad within 72 hours after to Department of Health and Mantal Hygiane. Important: if Item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Evantres once. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes X2X No Specify: þ 3 ☐ Widowed X Divorced White Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) æ Kenneth Gaynor Corona Janu ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robin Worthington POA/PR 6134 Fairborne Court Hanover, Maryland 21076 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2XXCremation 3 ☐ Removal from State GreenMount Cemetery 11/19/05 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc. ignature of Funeral Service Licensee 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one gause on each line. **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) Pulmonary Disease Chronic Obstructive years Examiner Due to (or as a consequence of): Examiner ba axecuted signed by tha attanding physician and d be detached for usa as the bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): Part !!. Other significant conditions contributing to death but not resulting in the underlying cause given in Part !. 23b. Dld tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Fibrillation Atrial à Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy performed? 65 HODO50515 1 Tyes 2 1 No 1 ∏ Yes 2 ∏ No Hospital or Attending Physician: 24 hours aftar death. Be 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 412 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ After this Certification: 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural aftar death. 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Hospital or within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signature end title of certifier 29c. License number 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) William D. Mc Connell Charles St. Baltomore MD 21212  $\sim$ . 6301 31. Date filed (Month, Day, Year) 32 Registrer's Signature State Registrar

DHMH 16 Rev 6/95

Amend item#20b perfil G850-12/2/05 II State of Maryland / Department of Health and Mental Hygiefiel 0 5 1 - For State Registrer Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death NOVEMBER 19, 2005 **Physician** MARY D. SEVERIN 5:55 p. M /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE STELLA MARIS NURSING HOME TIMONIUM 9. Birthplace (State or Foreign Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 11/29/ 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 87 Months Days Hours 1 □ M 2 🗓 F 218-05-0065 Yrs. MARYLAND Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No MD HOWARD ELLICOTT CITY Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21042 10030 WATERFORD DRIVE USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or itams 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2 🛣 No Specify: by 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER HOME 12th GRADE permit. Pages 1 and 2 should be filed Department of Health and Mental Hygis Important: If itam 27 is marked other any injury or other traumatic event. II 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be HOWARD STEINERT MOLLIE QUEALEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JACQUELINE BILLINGS/NIECE 10030 WATERFORD DRIVE ELLICOTT CITY, MD 2:1042 23° 11/<del>13/</del>05 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State GARDENS OF FAITH CEM. PARKVILLE, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility THE JOHNSON FUNERAL HOME P.A. 21. Signature of Funeral Service Licensee 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each list. Approximate Interval Between Onset and Death ETSLADING SEULEY Immediate Cause (Final disease or condition resulting in death) Priysician /Medical Due to (or as a consequence of): N/SHORELYCSIS YUS **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine be executed burial-transit and Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 □Ectopic pregnancy Month Day detached for 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other eignificant conditions contributing to death out not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 5-4446-02 6005301-24b. Were autopsy findings available prior to completion of cause of death? certificate has director, page 2 autopsy performed? 2 100 1 Yes 2 No of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Cther: 4 desidence 6 Other (Specify) 1 Yes 2 No After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: Division To the Hospital or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident Diractor: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the ne of centifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and 15504 11.2005. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY ROAD TIMONIUM, MD 21093

DHMH 17 Rev 1/2001

State

Registrar

EDDIE NAKHUDA, M.D.

NOV 2 2 2005

31. Date filed (Month, Day, Year)

SEVERIN, MARY

**ORIGINAL** 

32. Registrar's Signature

		i	For State Registrar	State of N	Maryland		artment o			nd M	ental Hyg	giene)	5 3	7660
	Physici /Medio		1. Decedent's Name (First, Middle Dawn	(e, Last)			Tit	on	)		2. Date of Dea Month Novem	Day	Year 7005	3. Time of Death
	Examir		4a. Facility Name (If not institution The Johns H  5. Social Security Number	topkins H	OSPITA Age (In yrs. la	ast birthday)	4b. City, To	Ifi	Location of	e	City 8. Date of Birt		y of Death	lace (State or Foreign
÷	Funeral Director		212-34-3012 Usual Residence of Decedent	1□ M 2[ <b>X</b> F	67	Yrs.		ays	Hours	Min.	8. Date of Birt (Month, Day 12-13-	1937	Bali	imore, MD
	he Marylar 8a-f ehow	ector	MD 10a. State 10b. County	n/a	10c. City	r, Town or Lo Ba	ltimo							0d, Inside City Limits  Y Yes 2 □ No
	23e or 2	Funeral Director	621 S. Wolfe	Street			10f. Zip Co	212	31			10g. Citizen of USA	What Cour	itry?
980	72 hours after death with the Maryland "netural", or Items 23e or 28e-f ehow idical Examiner must be notified at	by	11. Marital Status  1 □ Never Married 2 □ Mar  3 ☑ Widowed 4 □ Divorced	If Yes, Give	s? <b>∑</b> No		Was Deceden If Yes, specify 1 ☐ Yes 2X			in? (Spo Puerto	ecify Yes or No- Rican, etc.)	14. Ra Bla Speci	ce - Americ ack, White, ify: W	
Maryland 21215-0036	within ane. then '	Completed	15. Deceder (Specify only higher Elementary/Secondary (0-12) 12th	nt's Education st grade completed)  College (1-4c	or 5+)	(Give life.	dent's Usual C kind of work of DO NOT use i OMEMA	done du retired)	tion uring most	of work	ing	16b. Kind of I	Business/Ind	
/land	should be filed and Mental Hygin marked other matic event.	To Be C	17. Father's Name (First, Middle, Edward Kistr						18. Mother Ele		e (First, Middle, or Haas	Maiden Suma	me)	
			19a. Informant's Name/Relations John Titow	ship (Type, Print) SC		527	West	way	Gle	n B	al Route Numbe Burnie,		n, State, Zip 2106	
Baltimore,	of of or		20a. Method of Disposition  1    Butter 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (5)			klawn			111	1/2	2/2005		more	, MD
Ball	permit. Pag Department: Important: any injury o		21. Signature of Funeral Service  Marca M	Jonnes	nd	2	63 S.	Со	nkli	ng	seph N. St., E	Baltim		MD 21224
	Physician /Medical		23a. Part1. Enter the disease, of shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a Sch	sed the death h line. h eVVIC as a consequ	Cey	er the mode o		1		Distas			Approximate Interval Between Onset and Death
	be executed sician and purial-transit	Examiner	Sequentially list conditions, if any, leading to infine facto cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	. Di	as a consequ as a consequ as a consequ	s v	1 fa Mellit	rus	ive				2	2 weeks
.O. Box 68760,	death certificate e attending phy od for use as the	Physiclan/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		1 2 ∏Fetal tat time of de	death 3	Ectopic pregr Other (speci						ate of delive	ry Day Year
9	uires that the de signed by the lid be detached	by	Part II. Other significant conditions the HUPOH	ons contributing to death	h but not resu	ilting in the u	nderlying caus	se giver	n in Part I.			bacco use con	atribute to th	e cause of death?
Vital Records,	ien: The law requires that the rtificate has been signed by th stor, page 2 should be detache	Completed	Hyper	tension thing							24a. Was a autop perfor 1 X Yes	SV	prior to cor death?	psy findings available inpletion of cause of
of	Ing Physic After this ce uneral direc	tion; To Be	25. Was case referred to medical examiner?  1  Yes  2 No  27. Manner of Death 1 Vatural  5 Pendii	Hospital:		ER/Outpatier 28b. Time of Injury		Other	. 4 🗆 Nur	sing Ho	n (Check only or me 5 ☐ Resid 28d. Describe h	ence 6 Ot		*)
Division	ol or Attending after death. Director: After d in by the fune	Certification:	2 Accident investi 3 Suicide 6 Could 4 Homicide determ	not be 28e. Place of	Injury - At hor etc. (Specify,	me, farm, str				-	28f. Location (S City or Tow	treet and Num n, State)	ber or Rura	Route Number,
	To the Hospitel or I within 24 hours after To the Funeral Directorpletely filled in b	edical C	29a. Certifier (Check only one) 1 Certifyin 2 Medical	ng Physician: To the be Examiner: On the basis and manner	s of examinati	wledge, death ion and/or in	n occurred at t vestigation, in	he time my opi	e, date and nion, death	place,	and due to the deed at the time, o	ause(s) and m late and place,	anner as st	ated. the cause(s)
4	To the within To the comp	Me	29b. Signature and title of certified	siall-1	Tedeca	1 Doc 23a) (Type	ter 1		number	10		29d. Date signe Jovembe	v I	1,2005
	Sta Registi		Julia Syxllc. 31. Date filed (Month, Day, Year,	The Jehr	15 Hopk istrar's Signati	LINS F	tospital	(	000	Nov.	th cubif	e Street	i	altimore aniland 2128

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 15 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Tucker Day **Physician** 0930 AM November 20,2005 Debra /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** The Johns Hopkins Hospita Baltimore City N/A If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 05/01/1956 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 49 Hours 1 M 2 F 03-97-31 BERMUDA Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☑ Yes 2 ☐ No BERMUDA GEO2 ST. GEORGE Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 53 WELLINGTON SLIP ROAD GEO<sub>2</sub> BERMUDA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2√2 No Specify: δ 3 Widowed 4 XDivorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) RETAIL MERCHANDISER permit. Pages 1 and 2 should be filed wn Department of Health and Mental Hyglen. Important: If item 27 is marked other than any injury or other traumatic event, item 2006. 11TH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be SIDNEY FOX HELENA BURGESS ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) CR01 5 PETERS RD, SJONIECE T. BEAN/DAUGHTER HAMILTON PARRISH, BERMUDA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 11/29/05 GEORGE CEM. ST. GEORE, BERMUDA \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Euneral Service Licensee 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AVE, BALTIMORE, MD 23a. P. M. Erler the discusse, or complications that caused the dear. Do not enter the mode of dying, such as cardiac or respiratory arrest, shuck, or heart failure. List only one cause on each line.

Immedia: Cause (Final disease or condition)

a RESOLUTION FOLLOWS. Respiratory Failure
Due to (or as a construence of): **Physician** 2 hours resulting in death) /Medical Examiner renocarcinoma of weeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Malignant Pleural effusion
Due to for as a consequence of): weeks the attending physicien Physician/Medical nse 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? ō Month 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ page 2 should be 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? certificate 1 ☐ Yes 2 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Alter 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident after death 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

Division of Vital Records, P.O. Box 68760, filled in by the funeral director. within 24 hours a To the Funeral I completely

> NINA Wagner-Johnston 31. Date filed (Month, Day, Year) State Registrar

29b. Signature and title of certifier

MWasuer-Gomuston, MD 30. Name and address of be son who completed cause of death (Item 23a) (Type, Print)

29a. Certifier

Medical

Johns Hopkins Hospital 600 N. Wolfe St. Baltimore, MD 21205 32 Registrar's Signature Some L

DHMH 17 Rev 1/200

📆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D62878

29d. Date signed (Month, Day, Year)

November 20, 2005

State of Maryland / Department of Health and Mental Hygiene 05 1 - For Stete Registre Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** nomas Vovember e /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Number 6. Sex **Funeral** Months Davs Hours 6916 1 □ M 2 X F 19-28-Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c, City, Town or Location 10a. State 10b. County r then "neturel", or items 23a or 28a-f show the Medical Examinatinat be notified at 1 XYes 2 □ No more Director Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Or Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 XNo Baltimore, Maryland 21215-0036 Specify: Specify: þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life., OO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. Shie 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be a 2 treumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ( June 1911) permit. Pages 1 and 2 s
Department of Health ar
Importent: If Item 27 is
any injury or other treu < Date 20c. Locative - City of Town, State 20b. Place of Disposition (Name 20a. Method of Disposition cemetery, crematory or other place) 12005 1 Burial 2 Cremation 3 Removal from State • 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Home, P. A. Joseph W eral 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) bowel week Pnysician obstruction /Medical Due to (or as a consequence of) Examiner courcer wonths ucreatic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 Other (specify) the page 2 should be detached 9 Unknown 9 Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed 1 Yes 2 2 No Hospital or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c, Injury at Work? 28d. Describe how injury occurred Certification; 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. М 2 Accident within 24 hours after deat To the Funerel Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2 21, 2005 D23809 November 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mo 21201 22 S. Creene St., Baltemore Austra Doyle, Greenelous Cancer Ctr., MD 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 2 Registrar 2005

		- For Amend Item 5 Registrar	State of Maryla per me G850	nd / Dep. 12-13-0	artme rtifica	nt of H	ealth ar Death	nd Mental H	ygiene Reg. No. (	15	37663
Physici	an	1. Decedent's Name (First, Middle, Last,	THARP					2. Date of I Month	Death Day	Year	3. Time of Death
/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. Cit	y, Town, or	Location of [		4c. Coun	ty of Death	<u> </u>
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Funeral Director		014 15 CH11	X 7. Age (In yr	s. last birthday)	Month	er 1 Year s Days	If Under 24 Hours		Pay, Year)	9. Birthp Count	lace (State or Foreign itry) 31 w 1 A
and and		Usual Residence of Decedent  10a. State  10b. County	10c. (	City, Town or Le	ocation					1	0d. Inside City Limits
Mary	tor	MD BACTIM	TORE	BALTI	mol	E					1 ☐ Yes 2 ♣ No
death with the Maryland ms 23s or 28s-f show	Funeral Director	10e. Street and Number	^		10f. 2	Cip Code	-24		10g. Citizen o	^	itry?
s 23a	erall	3023 FAST	HVE.  12. Was Decedent Ever in	115 12	Was Doo	à 10	754	2 (Specify Ves or I		JSH ace - Americ	an Indian
after or Ite	by Fune	11. Marital Status  1 □ Never Married 2 □ Married  3 □ ₩ dowed 4 □ Divorced	Armed Forces?  1  Yes 2 No If Yes, Give	0.3.		2 No		n? (Specify Yes or t Puerto Rican, etc.)	Spec	lack, White,	etc.
72 hours "natural",		15. Decedent's Edu	Year or Dates:	16a. Dece	dent's Us	sual Occupa	ation		16b. Kind of	-	17E dustry
hin 72 9. Brn "ng	Completed	(Specify only highest grad	le completed) College (1-4or 5+)	(Give	kind of v DO NOT	vork done d use retired	luring most o )	f working			
o filed within the Hygiene.  other the Ment, Ire Ment, Ire Ment, Ire Ment	Con	7		$\perp$ $\mu$	OME	MAK		None (Final Adida		SIDEY	NCE
a la b €	To Be	17. Father's Name (First, Middle, Last)	ARNELL				ıΛ	Name (First, Midd	Puck		_
2 sho		19a. Informant's Name/Relationship (7)		_	ing Addre		Λ	or Rural Route Nurr			
s 1 and 2 should f Health and Mer item 27 Is marks other traumatic		OHIRL THARP - DI	aughter-in-lai	. Place of Dispe	sition (A	EAST	1	Date	20c. Location		
0 0 = =		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		cemetery, cre	-	PARK		ovenbel 3, 2005	Roi	cuille	mD
nit.		21. Signature of Funderal Service Licens					s of Facility	EVANS	FUNERA	76 C	MAPEL
Per Per Per Per Per Per Per Per Per Per		1/4/to B_	Ma	18	800	14	reford	R1.	PARKvill	E, M	0 21254
Physician		23a. Part1. Inter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition	lications that caused the de ne cause on each line.	i. 1		ode of dying		rdiac or respiratory	arrest,		Approximate Interval Between Onset and Death // munths
Attending Physician: The law requires that the death certificate be executed or refash.  Sector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit.	Ilcal Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b								
he death certifics the attending pt ched for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time o 9 □ Unknown	etal death 3	⊒Ectopic ⊒ Other	pregnancy (specify)				Date of delive	ory Day Year
uires that the d signed by the id be detached	þ	Part II. Other significant conditions co	ntributing to death but not r	esulting in the u	underlying	g cause give	en in Part I.		tobacco use co Yes 2 □ No		ne cause of death?
The law require ste has been si page 2 should t	Completed				<u> </u>			24a. Wi au pe	topsy rformed?	prior to cor death?	psy findings available mpletion of cause of 2□ No
ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Manager Co.			0.1		f Death (Check on)	y one)		
To the Hospital or Attending Physician: The within 24 hours after death.  To the Funaral Director: After this certificate his completely filled in by the funeral director, page	on: To	1 ☐ Yes 2 ☑ No  27. Mann of Death 1 ☐ Natural 5 ☐ Pending	Hospital: 1 ☐ Inpatient 2 28a. Date of Injury (Month, Day Year)	28b. Time of Injury		28c. Injun	4   Nurs	ing Home 5 Re 28d. Describ	e how injury occ		γ)
tendii leath. tor: A the fu	catle	2 Accident investigation 3 Suicide 6 Could not be	l		М		Yes 2 □ No		(2)		
tal or Attensis after death	Certification;	4 Homicide determined	28e. Place of Injury - Al building, etc. (Spe	t home, farm, st	treet, faci	ory, office			n (Street and Nur Town, State)	mber or Hura	il Houte Number,
To the Hospital within 24 hours a To the Funaral I completely filled	Medical	29a. Certifier 1 Certifying Phy (Check only one) 1 Medical Exam	rsician: To the best of my k iner: On the basis of exami and manner stated.	ination and/or in	nvestigati	on, in my o	oinion, death	occurred at the tim	ne cause(s) and i	manner as si e, and due to	tated. the cause(s)
To the within 3 To the comple	Μe	29b. Signature and title orcertifier	<i>d</i>		2	29c. Licens	number		29d. Date sign	ned (Month,	Day, Year)
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Second Security Number   Sec	Exan	nin	er				A							4c. Co	ounty of Deat	1	19
21 - 20-1-385   TAM CIF   80   Yrs.   Morthol Days   100 to   Morthol Days   100 to   Morthol Days   100 to	_					en mi							9 Date of Birt	h	O Riel	mlace (Ctate	or Foreign
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Physician   Micelical Examiner   Micelical Examin	I. Pa			4 Donation 5 Other	(Specify)							10	11/18/05	OWING	SS MILLS	6, MARY	LAND
Physician (Activation Examiner	Depa Impo	buce	П	21. Signature of Funeral Serv	Licenson	1/1	1.	22			_		Chanel P.C.				
Physician Middleal Examiner  The properties of the Underlying and Service Condition is sulfing in death   Last    The properties of the Underlying and Service Condition is sulfing in death   Last    The properties of the Underlying Cause (First   Service Condition			-	23a Part1 Enter the disease	or/complic	ations that o	aused the dea	th. Do not ent	163	39 No	rth Broa	adway	Baltimore	Marvia	and 2121	3 Approxima	110
Section   Column			j		ist only one	cause on e	ach line.				,, 0 - 0	<b>54</b> . 4.40 0	. roopa.o.y a.,	001,		Interval Be Onset and	etween
The part of the pa				disease or condition	_ a.				K							2 W	zeks
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IFFEMALE: 23b, Was adocated pregnant in the past 12 months?   1   1   2   2   2   0   3     Date of delivery   Month   Day	ate be nysici he bu		cal		d.												
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9   Unknown 9   Un	ath ce ttend or us		lan/	23b. Was decedent pregnant	23	1□Live b	irth 2 Fet	aldeath 3						230		•	Year
The completion of death   The completion o	the a	-  -	yslc	1 ☐ Yes 2 ☐ No				death 5∟	Other (spe	cify)					Wildlitte	Juy	7 041
The completion of death   The completion o	that the by detac		4		itions cont	ributina to de	eath but not re	sulting in the u	nderlying ca	use aive	n in Part I.		23e. Did to	bacco use	contribute to	the cause of	death?
1   Matural   1   Month, Day Year   1   Month, Day Year   1   Yes 2   No	sign sign			-				3	,	g			1	_			
1   Matural   1   Month, Day Year   1   Month, Day Year   1   Yes 2   No	w requ		ete										240 1460 0				
1   Matural   1   Month, Day Year   1   Month, Day Year   1   Yes 2   No	ne lav e has ge 2		d L										autops	sy	prior to c	ompletion of	cause of
1   Matural   1   Month, Day Year   1   Month, Day Year   1   Yes 2   No	in: T			25 Was case reterred to med	cal						00 01	-15			1 🗆 Yes	2 No	
1   Matural   1   Month, Day Year   1   Month, Day Year   1   Yes 2   No	s cert			examiner?	-	spitaf:	nnatient 2	TER/Outpation	3 000	Othe					Other (Con-	4.)	
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year  29d. Date signed (Month, Day, Year  29d. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Phy erthi	- 1	L i	27. Manner of Death		28a. Date	of Injury	28b. Time of								ny)	
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year  29d. Date signed (Month, Day, Year  29d. Name and address of person who completed cause of death (Item 23a) (Type, Print)	ndin ath r: Att		atio			(MOI)	ii, Day rear)	injury				No					
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	itai ol rs aft al Di									4							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	tosp 4 hou Funei ely fil		cal	(Check only 2 Medic	ying Physi al Examine	cian: To the	best of my kn	owledge, death	occurred a	t the tim	e, date and	d place, a	and due to the c	ause(s) an	d manner as	stated.	s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	the I the I the I		Med	One)		and man	ner stated.				,	-					-,
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	To To		_	250. Signature and title of cert		0	DACTER						2				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	P.	7		20 Name and odd						0006	101			NOV	EMBER	8,20	-05
WILLIAM HUND, MD, JOHNS HOPKINS BAYMEN MEDICAL CEPTER, 4940 EFSTERN AVENUE, BALTIMORE MA 21224		7								940	EASTER	N AND	NUE RA-	- , en. 20	a mb	21224	
		Stat	e_			1					_ , _ , , , , , , , , , , , , , , , , ,		יימין ייחנ	TIPLOK		-1007	
State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature			-	MOV 2	2 201	05	Partiture .	B. A.	recti								

			State  1- State Amend Item 28a,d,f Registrar	of Maryland / De per me G849 <sub>C</sub>	partment of Health and I eltificate of Beath	Mental Hygier	UUD .	37665
I	Physic /Medi		Decedent's Name (First, Middle, Last)     Nirm	ala Tannan		2. Date of Death Month November	9, 2005	3. Time of Death 7:54 P M
	Examir		4a. Facility Name (If not institution, give street and i	number)	4b. City, Town, or Location of Death		4c. County of Death	
25	1 A 250 + C-	Man	Holy Cross Hospital		Silver Spring		Montgomer	<b>V</b>
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 ☑ F	7. Age (In yrs. last birthda 66 Yrs.	Months Days Hours Min	8. Date of Birth (Month, Day, Yea	9. Birth	place (State or Foreign ntry)
70	p		Usual Residence of Decedent	00		December 15,	, 1938	India
	arylar ehow	_	10a. State 10b. County	10c. City, Town or	Location			10d. Inside City Limits
	the M.	Director	Maryland Montgomery  10e. Street and Number		Rockville			1 ☐ Yes 2X No
	with with Lean				10f. Zip Code	10g. (	Citizen of What Cou	
	death me 23	era	4503 Faroe P1 11. Marital Status 12. Was De		3. Was Decedent of Hispanic Origin? (Sp	pecify Yes or No-	United 14. Race - Ameri	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. item 27 Is marked other than "natural", or Iteme 23s or 28s-f show other traumatic event, the Medical Examinations must be invitibled at	by Funeral		s 2K No Give	<ol> <li>Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerton 1 ☐ Yes 2 X No Specify:</li> </ol>	Rican, etc.)	Black, White,	
5-0	72 hc	eted	15. Decedent's Education (Specify only highest grade complete	d) 16a. De	cedent's Usual Occupation	16b.	Kind of Business/In	
121	12 should be filed within "n and Mental Hygiene." I'ls marked other than "raumatic event, tra Med	Completed		(1-4or 5+)	ve kind of work done during most of work b. DO NOT use retired)	9		
	filed v Hygie ther t		17. Father's Name (First, Middle, Last)	4	Homemaker	e (First, Middle, Maid	Own F	lome
Maryland	ld be ental ked o	To Be	Gulzari La	1 Iarath	To. Mother's Hall			
ary	shou and M a mar	-	19a. Informant's Name/Relationship (Type, Print)		tiling Address (Street and Number or Rui	Satyavat  al Route Number, City		Code)
	and 2 ealth a n 27 ls		Vikrant Tannan/ Son		2 South Fallsmead W			
Baltimore,	m O		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 □ Removal from		Location - City or To			
Ë	Pages tment of h tent: If its jury or of		4 ☐ Donation 5 ☐ Other (Specify)	Cremat	orium Inc.   13,	2005 Be	thesda, M	laryland
Bal	permit. Pages 1 and 3 Department of Health Importent: If item 27 any Injury or other tru <u>ence</u> .		21. Signature of Funeral Service Licensee	₩00335	22. Name and Address of Facility Rob Bethesda—Chevy Chas Bethesda, Maryland	208 TTC 3501	phrey Fur 57 Wiscor	neral Home/ nsin Avenue
Р			23a. Part1. Enter the disease, or complications tha shock, or heart failure. List only one cause or	t caused the death. Do not e	enter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between
19	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	ultiple	Thyunes			Onset and Death
	Examiner		Due t	o (or as a consequence of):	O			
		er	Sequentially list conditions, b. Due to any, leading to immediate	o (or as a consequence of):				
	cuted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events					
Ó,	ificate be executed g physicien and as the burial-transit		resulting in death) Last Due to	o (or as a consequence of):				
68760,	ate b	edicai	d					
	± 09 €	/Me	IF FEMALE: 23c If yes o	utcome of pregnancy				
Вох	law requires that the death certifi as been signed by the attending i 2 should be detached for use as	Physician/M	in the past 12 months?	birth 2 Fetal death 3	B□Ectopic pregnancy B□ Other (specify)		23d. Date of delive Month	Day Year
o.	at the de by the tached	hysi	1 ☐ Yes 2 ☑ No 4 ☐ Pre 9 ☐ Unknown 9 ☐ Unk		Cities (specify)			
۳.	res that igned b	by P	Part II. Other significant conditions contributing to	death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	use contribute to th	e cause of death?
ğ	w require been sig should b					1 ☐ Yes	2d No 3□ Prob	ably 4 □Unknown
of Vital Records,	law n as be	ompleted				24a. Was an autopsy	24b. Were autor	osy findings available
<u>~</u>	The l	Con				performed? 1X Yes 2□N	death?	npletion of cause of 2 No
Vita	Physicien: this certific al director.	Be	25. Was case referred to medical examiner?  1 Types 2 Tho Hospital:		Y	Check only one		
ō		٠ <u>.</u>	TIME TO SELECTION TO	Inpatient 2 EP/Outpati		me 5 Residence		
O	Attending r death. ector: After by the funer	ertification:	1 □Natural 5 □ Pending (Mo 2 ■ Accident investigation	oth, Qay X ar) Injury		28d. Describe how in:	JUSSING S	reex
Division	or Attendi after death. Director: A in by the fu	ifica	3 Suicide 6 Could not be determined 28e. Place	e of Injury - At home, farm,		28f. Location (Street a	and Number or Rura	Route Number,
Ö	s afte	Cert	Dull	ding, etc. (Specify)	2	City or Town, Sta	( Connectic	ext Ane.
	To the Hospital or Att. within 24 hours after de To the Funeral Direct completely filled in by the	edical	29a. Certifier  (Check only (Check only 2 1 Medical Examiner: On the	ne best of my knowledge, dea	ath occurred at the time, date and place, investigation, in my opinion, death occurr	and de to the treet	prine Mc	tod
	the hin 2, the mplet	Med	allulla	nner stated.				
ı	S T W		29b. Signature and the of centifier	M	29c. License number O.C.M.E.		ate signed (Month, L	
	a		30 Name and address of person who completed	use of doubt (the most) (T		NOV	ember 10,	2003
	8		30. Name and address of person who completed car	44	1 Penn Street, Balt	timore Mos	cvland 21	1201
	Sta	-	31. Date filed (Month, Day, Year) 32.			LINUTE, I'ld!	rand 2	1201
	Registr	ar	NOV 2 2 2005	egistrar's Signature	Soul Soul			

			1 - For State Registrar	State of M	arylar		artmen rtificate				lental Hy	/giene		5	376	66
	Physic		Decedent's Name (First, Middle, Las     Vic	tor Josep	h Ve	ngrous	kie				2. Date of Domestin Novem	eath Da	v	Year	3. Time o	
	/Medi Examii		4a. Facility Name (If not institution, give	street and number)			4b. City,	Town, or	Location o	of Death	Novem	40	. County o	f Death	4:15	A
	Funeral Director		Social Security Number 6. S		88	last birthday) Yrs.	If Under Months		If Under	24 Hrs. Min.	8. Date of Bi (Month, D. April 1	-th		9. Birthp	lace (State	
	within 72 hours after death with the Maryland ene. than "natural", or Itams 23a or 28a-f show te Madical Examinat: Just be mullified at	rector	10a. State 10b. County  Maryland Montgom  10e. Street and Number	ery	10c. Cit	y, Town or Lo	Rockv		:			10- 00				ity Limits 2 🗌 No
	eath with ss 23a or	Funeral Director	1629 Lewis Avenue	12. Was Decedent	Francis III	2 10		20	851			Uni	ted	Stat	es	
9000	be filed within 72 hours after death with the Marylan hat Hygiene. sd other than "natural", or Itams 23a or 28a-f show other than "natural", or Itams 23a or 28a-f show event. Its Madical Examinational by multiped at	by	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ☑ Divorced	Armed Forces?  1 ⊠ Yes 2 ☐  If Yes, Give  Year or Dates:	Vo.	I	1□Yes 2	No No	Specify:	gin? (Spe , Puerto	ecify Yes or No Rican, etc.)	<b>D-</b>	14. Race Black Specify:	- America , White, a Whi	etc.	
21215-	e filed within 72 hal Hygiene. I other than "nativent, Ire Medica	Completed	15. Decedent's Ed (Specify only highest gra- Elementary/Secondary (0-12) 12	ucation de completed) College (1-4or 5	5+)	16a. Deced (Give life. L Secur	kind of wor DO NOT us	k done d e retired)	uring most	of worki	ing		ind of Bus eral		ustry ernmen	t
ryland	should be filed ind Mental Hygis marked other umatic event.	To Be C	17. Father's Name (First, Middle, Last) Felix Vengrousk:						A	goth						
Baltimore, Maryland 21215-0036			John Vengrouskie/S  20a. Method of Disposition	Son	20b. P	3825	Hallo	way	Circl	Le, T	Jpper M	ar1b		Mary	land :	20772
Baltimo	permit. Pages 1 and 2 Department of Health s Important: If itam 27 is any injury or other tra gncs.		1 Surial 2 Cremation 3 C 4 Donation 5 Other (Specify 21. Signature of Funeral Service Licen:	)	Ma <sup>2</sup>	emetery, crem ryland Cemet Ro	ery Name and bert	Address	of Facility umphr	2005 ey 1	Funeral	Hom	e/Roo	ckvi	laryla Lle, I	nc.
	Pnysician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition	ne cause on each III	the death	20 300	West or the mode	Mont	gome	ry A	ve., Roc	:kvi]	1e, N	4D 20	850-280 Approximate Interval Bet Onset and I	)5 e ween
	/Medical Examiner	į.	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as Diabet  Due to (or as	a consequ :es	uence of):									ronte	
8760,	cate be executed oblysician and the burial-transit	dicai Examiner	cause. Enter Underlying cause (Disease or Injury that initiated events resulting in death) Last	c. Hypert  Due to (or as	ensi	on								Cł	ronic	
P.O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal	death 3 🔲	Ectopic pre Other (spe					2	3d. Date of Month			'ear
	w requires that been signed b should be deta	by	Part II. Other significant conditions co Stroke, Benign Pro				derlying car	use giver	in Part I.	112		_	_		cause of d	
al Records,	: The law re cate has be page 2 sho	Completed	Psoriasis, Neuropa	thy									prio dea	or to com- th?	sy findings a pletion of ca	
Division of Vital	Attanding Physician: Thr death. ector: Alter this certificate by the funeral director, pag	tion: To Be	25. Was case referred to medical examiner?  1 X Yes 2 No  27. Manner of Death  1 X Natural 5 Pending 2 Accident Investigation	Hospital: 1 ☐ Inpatie 28a. Date of Injur (Month, Day	y	ER/Outpatient 28b. Time of Injury		Other c. Injury a Work?	4 □ Nurs	sing Hom	(Check only only only only 5 Neside State of the second o	lence 6		(Specity)		
Divisi	To tha Hospital or Attanding within 24 hours after death. To tha Funaral Diractor: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injubulding, etc	ry - At hor - (Specify)	me, farm, stre				-	8f. Location (S City or Tow	Street and m, State)	Number (	or Rural I	Route Numb	00r,
	To tha Hospi within 24 hou To tha Funar completely fill	Medicai	one)	sicien: To the best oner: On the basis of and manner sta	examınatı	vledge, death ion and/or inve	estigation, i	n my opir	nion, death	place, ar occurre	nd due to the d d at the time, d	ause(s) ; date and	and manne place, and	er as stat I due to t	ed. ne cause(s)	
)	with To	2		Hu			3 I	License (					signed (Member			
	10		30. Name and address of person who con Douglas R. Shumake 31. Date filed (Month, Day, Year)	r, M.D.	615 T	West Mo		nery	Aven	ue,	Rockvi	lle,	Mary	land	2085	0
	Sta Registr	200	MOV 2 2 2005	Registra		LIFE COMM	W									

FRANKLIN CHARLES NYSKOCIL

			Please			ck Indelible In Department of		-	_	
		1 - Stete Registrar		Oldio of IVI	arylana /	Certificate of			2005	37667
		1. Decedent's Name	(First, Middle, Las	t)				2. Date of Death		3. Time of Death
	sician edical	FRAC	iKLin 1	HARLE	S VY	SKOLIL		Month MVEN NEX	Day Year	1204 PM
Exar	niner	4a. Facility Name (If	not institution, give	street and number)			or Location of Death		4c. County of Dea	th
		5. Social Security Nu	mber 6. Se	URIVE	To /la ura la at h	pirthday) If Under 1 Year	If Under 24 Hrs.	O. Data of Blish	HARF	ora
Funer Direct	_	0		CO	ge (In yrs. last b	Yrs. Months Days		8. Date of Birth (Month, Day, Y	(ear) 9. Bin	thplace (State or Foreign
D		Usual Residence of D	- 0 1		1 1			C27 14	MOTITION	asyl-4110
anylan ehow	_	10a. State	10b. County		10c. City, To	wn or Location				10d. Inside City Limits
he M	Director	LA-	HUMB	7010	20	RIKA				1 ☐ Yes 2 No
death with the Maryland ms 23e or 28e-f ehow froat be notified at	ä	10e. Street and Numi		-1 \ 0	_	10f. Zip Code		10g	. Citizen of What Co	ountry?
death ms 23	Funeral	11. Marital Status	2REA!	12. Was Decedent	Ever in U.S.	13. Was Decedent of	Hispanic Origin? (Spe	ecify Yes or No-	14. Race - Ame	erican Indian
after or Ite	Ē	1 Never Marrie	d 2 Married	Armed Forces?  1-10 Yes 2 []  If Yes, Give	No No	13. Was Decedent of If Yes, specify Cut		Rican, etc.)	Black, Whit	e, etc.
2-UUSO 72 hours after naturel', or ite	d by	3 ☐ Widowed 4	Divorced	Year or Dates:	Truiw	1 ☐ Yes 26 No	Specify:		Specify: W	3/1/6
IIIG Z IZ IS-UUSO be filed within 72 hours after death with the Marylan thygiene. d other than 'naturel', or Items 23e or 28e-f ehow event, the Madical Examiner must be multired at	Completed	(Specif	15. Decedent's Ed y o <i>nly highest gra</i>	ucation de completed)	16	a. Decedent's Usual Occu (Give kind of work done	during most of working	ng 16	b. Kind of Business/	Industry
within ene then the Me	E G	Elementary/Second	dary (0-12)	College (1-4or	5+)	life. DO NOT use retire	0		つーい.	-\
filed Hygi ent,	ပိ	17. Father's Name (F	irst, Middle, Last)	<u> </u>		STEEW	18. Mother's Name	(First, Middle, Ma	iden Sumame)	1/6
should be ad Mental marked of metic ev	To B	AME	0	VYSKOR	1		( ) AR.	1		
int. Pages 1 and 2 should arment of Health and Men ortent: If item 27 is marke injury or other treumetic		19a. Informant's Nan				b. Mailing Address (Stree	t and Number or Rura	l Route Number, C	ity or Town, State, 2	Zip Code)
1 and 2 Health tem 27 Ither trees		PAUL W-	MANAY	ER_	}	Sival 80	SLANE C	ELAIR!	TARALAC	HOLE OF
ges 1 au f of Hea f item or othe		20a. Method of Dispo		Removal from State	20b. Place	of Disposition (Name of ery, crematory or other pla	Sol Por?	ate 2	c. Location - City or	Town, State
Dalling permit. Pag Department Importent: any injury o		`4 Donation 5	Other (Specify	)	- 5 B	THIR OA	30	-	WHOTEEN	CARTISALIZ
Dall permit. Departi Importa any inji	SUC.	21. Signalura of Fun	Tal Service Licen.	90		22. Name and Address	ess of Facility HA	pel-Bu	LAIR, P.	4.
		23a. Part1. Enter the	disease, or comp	Vicetion that caused	d the death. Do	not enter the mode of dy		r respiratory arrest	(177 1 XXXX	Approximate
Physicia		Immediate Cause (F	ratiure. List only o	ine cause on each li	ne.			^		Interval Between Onset and Death
/Medica		disease or condition resulting in death)	-	a. Linea Due to (or as	a consequence	stic Carchi	:VII Cule	er dise	522	
Examine	er	Conventigible list cons	ditions	b		,				
ם ב	ne ne	Sequentially list cond if any, leading to imm cause. Enter Underly	nediate ying		a consequence	of):				
ecute and I-trans	Examiner	Cause (Disease or in that initiated events resulting in death) La		C	a consequence					
be ex ician a	_			Due to (or as	a consequence	, 01).				
leath certificate be executed attending physician and for use as the burial-transit	Physician/Medica		•	d						
certi anding use a	Z	IF FEMALE: 23b. Was decedent p	pregnant	23c. If yes, outcome	of pregnancy				23d. Date of deli	verv
death death e atte	lcla	in the past 12 m	onths?	1 ☐ Live birth 4 ☐ Pregnant at		h 3 □Ectopic pregnand 5 □ Other (specify) _	y 		Month	Day Year
at the	hys	9 Unknown		9□ Unknown						
res th igned	þ	Part II. Other signific	ant conditions co	intributing to death b	ut not resulting	in the underlying cause gr	ven in Part I.		co use contribute to	
requir been s	eted	- Hype	1 Lewign					1 Tes	2 ØNo 3 ☐ Pro	obably 4 Dunknown
e law has t	Completed	Deal	erres		-			24a. Was an autopsy	prior to c	topsy findings available ompletion of cause of
n: Th ficate or, pag		05 11/-	d 4					performed 1 ☐ Yes 2	l? death? No 1 ☐ Yes	2 No
sicien sicien centilirecto	o Be	25. Was case referred examiner?		Hospital: 1 ☐ Inpatie	ent 2 ER/O	Ott	26. Place of Death			
arthis eral d	n: To	27. Manner of Death		28a. Date of Inju (Month, Da		Time of 28c. Inju	ry at 2	8d. Describe how i	e 6 □Other (Specinjury occurred	ify)
ath. Fr: Afte	atio	1 Natural 2 Accident	5 Pending investigation	(Month, Day	y Year)	Injury Wo	rk? ]Yes 2 □No			
r Atte er de recto	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Injuding, etc	ury - At home, f	arm, street, factory, office	2	8f. Location (Stree City or Town, S	t and Number or Rui	ral Route Number,
res aft				4						
To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours start death.  Within 24 hours after death.  When Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 (Check only 2 one)	Certifying Phy Medicel Exemi	I <b>ner:</b> On the basis of	examination at	e, death occurred at the tind/or investigation, in my o	me, date and place, a opinion, death occurre	nd due to the caused at the time, date	e(s) and manner as and place, and due	stated, to the cause(s)
o the ithin 2 o the	Med	29b. Signature and tit	le of certifier	and manner sta	1180.	29c. Licens	se number	29d.	Date signed (Month)	Day Year)
F 3 F 8		▶ As	0111	. 111 A	1/=	M	14201	/	- 0 i	
1		30. Name and addres	s of person who o	ompleted cause of d	eath (Item 23a)	(Type, Print)	1700	10	water!	1,000
1		BERNARD	\$ V41	CAR MA.	DRE	7018 HOLA	BIRA AL	VE AND	TO IN	21223
	State	31. Date filed (Month,	Day, Year) OV 2 2 20	32. Registra	ar's Signature		27-21 741	LANCE OF THE PARTY	10	- / -
Regis	_	141	- W W W Z(	No.	w St	park				
DHMH 17 Rev 1	1/2001				-	) <del></del>				

Helen Wallace UNK 05-06030 05-06030 RPD

1 - For State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item per the 9850 12-6-05 yt and Mental Hygiene 0 5

Certificate of Death

Reg. No. 37668

	Physici		1. Decedent's Name (First, Middle, Last)	Beatrice Wa	11204	9		2. Date of Month Septe	Death ember	<sup>ay</sup> 3, 2005	3. Time of Death
	/Medio Examin		4a. Facility Name (If not institution, give s 1821 Porter Avenue	treet and number)	iiiacc	4b. City, Town, or Suitland	Location of D		4	c. County of Death	
	Funeral Director		221-05-6705	м 2 <b>X</b> F 7. Age (In yrs. i.		If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Date of (Month, NOV 3	Birth Day, Year 19	9. Birth Cou 14 Del	place (State or Foreig ntry) aware
	within 72 hours after death with the Maryland one. then "natural", or Itams 23s or 28s-f show he Mcdical Examiner must be notified at	tor	Usual Residence of Decedent  10a. State  10b. County  Maryland Prince Ge		, Town or Lo		itland				10d. Inside City Limits
	or 28g	Director	10e. Street and Number			10f. Zip Code			10g. C	itizen of What Cou	ntry?
	23a	ral	1821 Porter Ave			2074				USA	
	er de	une	T. Maria. States	2. Was Decedent Ever in U.S Armed Forces?	S. 13. V	Was Decedent of H f Yes, specify Cuba	ispanic Origin In, Mexican, P	? (Specify Yes or Juerto Rican, etc.)	No-	<ol> <li>Race - Amen</li> <li>Black, White,</li> </ol>	
036	urs aft	by Funeral	1 ☐ Never Married 2 ☐ Married 3 ☐ Wildowed 4 ☐ Divorced	1 □ Yes 2 ሺ No If Yes, Give Year or Dates:	1	I□Yes 2XINo	Specify:			Specify:	Black
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or Itams 23e or 28e-f show any injury or other traumatic avant, the Medical Examinar must be notified at once.	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	(Give	lent's Usual Occup kind of work done o DO NOT use retired	during most of	working	16b. i	Kind of Business/In	ndustry
7	ed wit ygiene yer thu	Соп	12			Clerk				deral Go	vernment
ğ	be fill Hard of Hard	Be	17. Father's Name (First, Middle, Last)	1			18. Mother's	Name (First, Mide		n Sumame)	
2	hould d Mer marks marks	ှင	Adam Greenfiel  19a. Informant's Name/Relationship (Type		19h Mailin	a Address (Street	and Number of	Julia Pe		or Town, State, Zip	o Cado)
S	id 2 sl ith an 27 is r traur		Julianne Bethea/N			6 Monroe					0 0000
<u>6</u>	s 1 and 1 Heal		20a. Method of Disposition	20b. PI		sition (Name of natory or other place		Date		_ocation - City or To	own, State
Ë	Page nent o int: If iry or		1 ☐ Burial 2 X Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	antoval ilolli State		ematory,	1	1/22/05		Baltimore	e. MD
att	permit. Depertu Imports any inju		21. Signature Puneral Service License	2 miles		. Name and Addres				ciety of	
	205 = 9		Edward A. Gre							re, MD 21	
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.	,				•		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a consequence	POTIC	- CARPI	0 1 1 2 C	culon	1) (	25/2/25	
	Examiner		ACTION AND ADDRESS OF THE PARTY	Dao to (or as a consequ	201100 01).						
	D #	ner	f any, leading to immediate cause. Enter Underlying Cause (Disease or injury								
	ecute and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	. Due to (or as a consequ							
1760,	ite be ex iysicien a iysicien a	Ical E	d.	. Due to (or as a consequ	ience or):						
.O. Box 68760,	the death certificate be executed y the attending physicien and iched for use as the burlat-transit	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	3c. If yes, outcome of pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	Ectopic pregnancy Other (specify)			-	23d. Date of deliver Month	ery Day Year
ds, P	w requires that the dispension of the should be deteched	δ	Part II. Other significant conditions con	tributing to death but not resu	ulting in the ur	nderlying cause give	en in Part I.		d tobacco		he cause of death?
Division of Vital Records,	The law requires that the ste has been signed by the page 2 should be deteche	Completed						24a. W	itopsy irformed?	prior to co	opsy findings available impletion of cause of
ta	Physician: r this certifical ral director, p	Bec	25. Was case referred to medical examiner?					Death Check on			
5	Physic this c	ို	Y⊠Yes 2 No H		ER/Outpatien		4   Nursii	ng Home 5 Re		6 Other (Specif	y at scen
u	ding l h. After funer	tlon	1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun Work	/at k? Yes 2 ∐No	28d. Describ	e now inju	ury occurred	
Divisi	To the Hospital or Attending Physicien: The law within 24 hours after death.  To the Funeral Director: After this cellificate has completely filled in by the funeral director, page 2	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, stre			28f. Location City or	n (Street a Town, Stat	nd Number or Rura te)	al Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical C	25a. Continue 1 Gentifying Physical (Check only one) 2 X Medical Examin	dician. To the bost of my knowner: On the basis of examinat and manner stated.	wledge, death tion and/or inv	restigation, in my o	ie, date and p pinion, death o	lace, and due to the concourred at the time	lie cause(s ie, date ar	s) and manner as s nd place, and due to	ilated. o the cause(s)
	To the To the Comp	Ň	29b. Signature and title of certifier	e Chill w	)	29c. Licenso				ate signed (Month, tember 4,	
	2		30. Name and address of person who con			Print)			-		·
			31. Date filed (Month, Day, Year)	KIREU 1 32 Registrar's Signat		n Street	, Balt:	imore, Ma	aryla	nd 21201	
	Sta Regist		NOV 2 2 2005		B	6					
				2015 1207 3 58							

			For State Registrar		State of M	larylan	-	artment rtificate			and M	lental Hy	giene Reg. No.	05 3	37669
e ;	* *		Decedent's Name (First, Midd	e, Last)								2. Date of De Month	ath Day_	_Year _	3. Time of Death
1	Physicia /Medic	al	Imelda Bernie		Weakland							Novemb		, 2 <sup>Y</sup> 005	2:00 PM
1	Examin	C1 1	4a. Facility Name (If not institution	_	reet and number	r)		,,,	rown, or ndall	Location of	of Death			ounty of Death 1timore	2
		100	1769 Stokesley 5. Social Security Number	6. Sex	7. A	age (In yrs. i	iast birthday)	If Under	1 Year	If Under		8. Date of Bir	*h	0 Rieth	alaga (Ctata or Foreign
	Funeral Director	.	196–18–1487		M 2XXF	85	Yrs.	Months	Days	Hours	Min.	Sept.	24,192	0 Penns	sylvania
	P ,		Usual Residence of Decedent  10a State 10b Count			100 Cib	y, Town or Lo	reation							10d. Inside City Limits
	shov	5				100. 010	Dunda								1 □ Yes 24020No
	the N 28a-f	rect	Maryland Balti	поте			Durida.	10f. Zip	Code				10g. Citize	n of What Cou	ntry?
	3a or		1769 Stokesley	Road				2	2122	2			U.S.A	. •	
	within 72 hours after death with the Maryland ene. than 'natural', or items 23e or 28e-f show the Modical Exeminations to notified at	Funeral Director	11. Marital Status	12	2. Was Deceder Armed Forces	t Ever in U.	S. 13.	Was Deced	ent of Hi	spanic Ori	igin? (Sp	ecify Yes or No Rican, etc.)	)- 14.	Race · Ameri	
ထ္ထ	or its		1 Never Married 2 Ma		1 ☐ Yes 2√2 If Yes, Give	<b>X</b> No		1□Yes 2		Specify:			S	necify:	
Ö	hours tural,	ed by	<b>3</b> Widowed 4 □ Divorce		Year or Dates	i: 	16a Dece	dent's Usua	I Occun	ation			16b. Kind	of Business/In	ite ndustry
,	in 72 n na	Completed	(Specify only high	st grade	completed) College (1-4o	r 5 . \	(Give	kind of wor DO NOT us	k done d	turing mos	it of work	ring			
212	d with giene.	E O	Elementary/Secondary (0-12) 12		College (1-40	1 3+)	Rece	ption	ist				Medi		
2	be filed that Hygie of other is	Be	17. Father's Name (First, Middle									e (First, Middle		ımame)	
Maryland 21215-0036	should the should the should the should the should be sh	၉	Stephen Ambrose				105 115	4.14	(0)			eora Ri		Town State 7	- Codel
Mar	12 sh h and 7 is m traum		19a. Informant's Name/Relation Kimberly Anne I			uahta						Baltim			
	t and 2 Health tam 27 t		20a. Method of Disposition	avaı	iey (Da		Place of Disponentery, cre				iuo,	Date		tion - City or T	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if itsm 27 is marked other than "natural", or itsme 23a or 28a-f show any injury or other traumatic event, the Modical Examinational be notified at once.		1 ⊠ Burial 2 ☐ Cremation 4 ☐ Denaylon 5 ☐ Other		moval from Stat		rdens (				lov.	23,2005	Balti	more, 1	Maryland
≡ E	mit. F partm sortar / inful		21. Si n there of Funeral Service	//-	2	/.				s of Eacili	ngk:	Funer	al Hom	ne. P.A	
m	Depa Impo any i		Federal L	11	177	-								, Mary	land 21221
13h			30a. Part1. Enter the disease, shock, or heart failure. Vis	r complication	ations that caus e cause on each	ed the deat line.	h. Do not en	ter the mod	e of dyin	g, such as	cardiac	or respiratory	rrest,		Approximate Interval Between Inset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	_ a.	My	OCEN	dol	10	a.	rch	10-	1			1 hour
	/Medical Examiner		resulting in douting		Due to (o	as a conseq	uence of):	0	el	ita	1.1				
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b.	Due to (or a	as a conseq	uence of):	N/C		) ( )	7				
	ite be executed hysicien and he burial-transit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	٢.	Cer	rebro	ova/	ular	a	Ca	de	M-			
ó	be executed icien and burial-transit		resulting in death) Last		Due to (or a	as a conseq	quence of):					- 0			
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Box	attend for us	lan	23b. Was decedent pregnant in the past 12 months?	20	1 ☐ Live birth 4 ☐ Pregnant	2 Feta	al déath 3 l	⊒Ectopic pr ⊒ Other (sp		,			23	Month	Day Year
o.	0 0 0	nyslo	1 ☐ Yes 2 🛣 No 9 ☐ Unknown		9□ Unknown				//						
<u>α</u>	de de	by Pi	Part II. Other significant condi	ions conf	tributing to death	but not res	sulting in the i	underlying c	ause giv	en in Part	l.	23e. Did	tobacco use	contribute to	the cause of death?
rds	w requires been sign should be									-		1)×	Yes 2	No 3 ☐ Pro	bably 4 Unknown
000	lawre as bed 2 sho	plet											ppsy	prior to co	opsy findings available empletion of cause of
Division of Vital Records,		Completed											ormed? 2.⊠No	death? 1 ☐ Yes	2 🗌 No
/ita	Physicien: this certific ral director,	Be	25. Was case referred to medic examiner?		ospital:				Oth	0.00		th (Check only			
of	Physical distribution	- To	1 Yes 2 No		1 Inpa		ER/Outpatie		JA	4 LJ N	ursing H	ome 5 A Res 28d. Describe		Other (Speci	ify)
0	Attending ir death. ector: After by the funer	ton	1 Natural 5 ☐ Pend	ing tigation	(Month,	Day Year)	Injury	М	8c. Injur Wor □ 1	k? Yes 2 ⊑	]No				
isi	Atten r deal ector	ifica	3 ☐ Suicide 6 ☐ Coul	-	28e. Place of			treet, factor	y, office				(Street and	Number or Rur	ral Route Number,
ā	s afte el Dir	Certification:	4 _ Homode		building,	etc. (Speci	· <i>y</i> /						, 0.2.07		
	To the Hospital or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funerel	edical	(Check only 2 Medic	ing Phys Il Examin	ician: To the be	s of examina	owledge, dea ation and/or i	th occurred	at the til	ne, date a pinion, de	nd place ath occu	, and due to the rred at the time	cause(s) a , date and p	nd manner as lace, and due	stated. to the cause(s)
	To the P within 2 To the I complet	Med	one) 29b. Signature and title of certifications	ier	and manner	stated.		29	c. Licens	e number			29d. Date	signed (Month	, Day, Year)
	5 ½ 5 S	1	DAR	ML	11	~ w	9			289	49			2110	
	10		30. Name and address of person	n who co	mpleted cause	of death /Ite	m 23a) (Tvne			- '			111		
	10		Panayiotis Bal						Ste	. 102	Ro	sedale	Md.	21237	
1		ate										-			
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Amend Item 8 per fth G849 II-22-05 tas Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth November 2, 2005 Wills Physician DOROTHY 10 30 AM /Medical 4b. City, Town, or Location of Death 4e Facility Name (If not institution, give street end number) 4c. County of Death Examiner INEBORO CARROLL CARROLL WAREHINE 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth **Aptroph**, Day, Year) **May** 6,1918 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 K F Days Months Hours Director 218-05-5163 87 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after deeth with the Marylend nent of Health and Mentel Hygiene. Int: If Item 27 is marked other than "natural", or Items 23a or 28s-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Director Maryland Carroll Lineboro 10e. Street end Number 10f. Zip Code 10g Citizen of What Country? 5235 Carroll Warehime Road 21102 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2X No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: þ White Specify: 3x Widowed 4 □ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Own Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry Heise Mary 2 (unk) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) George Wills, Son 5235 Carroll Warehime Road, Lineboro, MD 21102

of Disposition (Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of himportant: If its eny injury or ot once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State Dulaney Valley Memorial Gardens 11/05/05 Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley, P.A. Brian T. Chisholm Funeral Services of 21. Signature of Fune al Service Lic 200 E. Padonia Road, Timonium, Maryland 21093 MD1113 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death **Physician** /Medical Immediate Cause (Final 4 disease or condition resulting in death) 4/453 Examiner Due to (or es a consequence of): Examiner or Attending Physicien: The law requires that the death certificate be executed efter death. Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or as a consequence of): for use Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of deeth? 1 Yes 2 No 3 Probably 4 Unknown ete hes been signed page 2 should be del þ Be Completed 24a. Was en autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? certificate has 1 Tes 2 - No 1 ☐ Yes 2 ☐ No filled in by the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home Medical Certification: To 1 Yes 2 No 5 Residence 6 □Other (Specify) After this 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Injury efter death. 1 ☐ Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours e To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Yeer) 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) Business (Into Drive Sinctho ushnu 31. Date filed (Month, Day, Year) State Registrar

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NOVEMBER 19, 2005

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	1 - State of Maryland / Department of Health a  Certificate of Death	
% <sup>1</sup> 1	1. Decedent's Name (First, Middle, Last)	2. Date of Death 3. Time of Death
ian ical	al William waiter whitty, Sr.	November 19, 2005 10:38 A M
ner	Stella Maris Timonium	Baltimore
	5. Social Security Number 6. Sex 1 M 2 F 80 Yrs. last birthday) If Under 1 Year If Under 2 Hours	24 Hrs. 8. Date of Birth (Month Day, Year) 9. Birthplace (State or Foreign Country) 9. Birthplace (State or Foreign Mary Land
	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
otor		1 ☐ Yes 2 M No
Dire	10e. Street and Number   10f. Zip Code   21234	10g. Citizen of What Country?
by Finers	MD Baltimore Parkville    10e. Street and Number   8409 Nunley Drive Apt. D   21234	gin? (Specify Yes or No- h, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.  Specify: White
nieted	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most life. DO NOT use retired)	t of working
E	Elementary/Secondary (0-12) College (1-4or 5+) Electric Troubleshoo	oter B.G.E.
Ba C	17. Father's Name (First, Middle, Last) Walter T. Whitty  18. Mothe	er's Name (First, Middle, Maiden Surname) Roche
	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number	er or Rural Route Number, City or Town, State, Zip Code) Apt. D; Parkville, MD 21234
	20a. Method of Disposition  1	Date 20c. Location - City or Town, State 11/22/05 Parkville, MD
	4 Donation 5 Other (Specify) Parkwood Cemetery  21. Signature of Fund Service Licensee 22. Name and Address of Facility	
	Ruck Towson Fur	1030 TOLK KOAU
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  PANCREATIC CANCER  Due to (or as a consequence of):	cardiac or respiratory arrest, Approximate Interval Between Onset and Death
amine	Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.	
licai F	Due to (or as a consequence of):	
	FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   Yes 14   Pregnant at time of death   Yes 2   No 9   Unknown   Yes 2   No 9   Unknown   Yes 2   No 9   Unknown   Yes 2   No 9   Unknown   Yes 3   Yes 4   Pregnant at time of death   Yes 4   Pregnant at time of death   Yes 4   Pregnant at time of death   Yes 4   Pregnant at time of death   Yes 4   Pregnant at time of death   Yes 4   Pregnant at time of death   Yes 5   Other (Specify)   Yes 4   Pregnant at time of death   Yes 5   Other (Specify)   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 6   Yes 7   Yes	23d. Date of delivery Month Day Year
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tion. T		28d. Describe how injury occurred
ortifica	27. Manner of Death  1 Natural 2   Accident 3   Suicide 4   Homicide  28a. Date of Injury (Month, Day Year)  28b. Time of Injury at Work?  M 1   Yes 2   Injury at Work?  28e. Place of Injury - At home, farm, street, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
Cicol	29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number	ind place, and due to the cause(s) and manner as stated.  th occurred at the time, date and place, and due to the cause(s)
Mo	29b. Signature and title of certifier  29c. License number	29d. Date signed (Month, Day, Year)
1	D4372	-5 11/21/05
4	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMOI	NITIM MD 21002
tate	01 D - 61 101 11 C - W - 1	NIUM,MD 21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar			State	of Mar	•				lealth Death		Mental Hy	giene	nn	5	3767	13
2	Physicia /Medic		1. Decedent's Nam		R.	1	NIL	BUR						2. Date of De Month	Da	16	<b>300</b> 0±	3. Time of	Death M
	Examin	er	4a. Facility Name (	If not institution		14/1		LENTE		1	, L	Location	of Death			County	of Death	UNDE	۲
	Funeral Director		5. Social Security N 144-24-5	lumber	6. Sex	M 2XF	7. Age (	In yrs. last birth 77 Y		If Under Months			r 24 Hrs.	8. Date of Bi (Month, Di 3-26-1	rth ay, Year) .928		9. Birth Cou	olace (State of otry) NY	r Foreign
	ryland how		Usual Residence o 10a. State	10b. County		<u>.</u>	1	0c. City, Town										10d. inside Cit	
	the Ma 28a-f s	Funeral Director	MD 10e. Street and Nu	Anne A	rund	le1		Gibso	on I	slan					10g. Cit	tizen of W	Vhat Cou	1 ☐ Yes	2 <b>X</b> No
^′	23a or	aiDi	731 Broa	dwater	Way					1	056						SA		
(7x	urs after dea al', or Items Examiner m	by	11. Marital Status 1 ☐ Never Marr 3 ☐ Widowed		ried	2. Was Dec Armed F 1 Tes If Yes, G Year or I	orces? 2 <b>A</b> No ive	er in U.S.		as Deced Yes, spec ☐ Yes 2		lispanic C an, Mexica Specifi		pecify Yes or No Rican, etc.)	0-		k, White,		
HNE 21215-0036	iit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland ariment of Health and Mental Hygiene.  ortant: if Item 27 is marked other than "natural", or Items 23a or 28a-f show injury or other traumatic event. The Medical Examinet must be multified at the second of the continuation of the model.	Completed	(Spec	15. Deceden cify only highe ondary (0-12)		completed	) (1-4or 5+)		(Give ki life. D0	nt's Usua nd of wor NOT us make	k done d e retired	ation during mo	ost of work	king		and of Bu		dustry	
land	2 should be filed with and Mental Hygiene. Is marked other that sumatic event. Ins.	To Be Co	17. Father's Name Alexand											ne (First, Middle Smith	e, Maider	Sumam	ө)		
Mar	id 2 sho Ith and 27 Is my traum		19a. Informant's N Leroy Wi					11	_			and Num.		ral Route Numb ibson I	-			21056	
	of Hea		20a. Method of Dis	position				20b. Place of cemetery						Date	20c. L	ocation -	City or T	own, State	
WILE altimore,	permit. Pages 1 and 2 Department of Health a Important: if Item 27 is any injury or other tra		4 ☐ Donation 21. Signature of F	5 Other (S	pecify)			Chesape				1		9-2005 ngleton				-	
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8760,	eath certificate be executed attending physicien and for use as the burial-transit	sicai Examiner	Sequentially list or if any, leading to it cause. Enter Und Cause (Disease or that initiated event resulting in death)	mmediate erlying - riyiny - s s Last	c. d.		-115	onsequence o											
P.O. Box 68760,	the d	Physician/Med	IF FEMALE: 23b. Was deceder in the past 12 1 Yes 2 9 Unknown	months?	23	1 Live	birth 2	pregnancy ☐ Fetal death ne of death		Ectopic pr Other <i>(sp</i>		1				23d. Date Mor		•	′ear
	uires that the signed by Id be detac	þ	Part II. Other signi	ficant conditi	ons cont	ributing to	death but	not resulting in		derlying c	ause giv	en in Par	t I.		tobacco			he cause of do pably 4 □U	
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Divisio	l or Attending after death. Director: After I in by the fune	Certification:	2 Accident 3 Suicide 4 Homicide	6 Could determ		28e. Plac	ce of Injury ding, etc.	r - At home, far (Specify)	m, stree			165 2[		28f. Location City or To	(Street ar own, State	nd Numbe e)	er or Run	al Route Numi	ber.
9	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edicai	29a. Certifier (Check only one)	1 Certifyi 2 Medical	ng Physi Examin	er: On the	ne best of basis of e nner state	xamination and	, death of	occurred estigation	at the tin	ne, date a	and place, eath occur	, and due to the rred at the time	cause(s , date an	and ma d place, a	nner as s and due t	tated. o the cause(s)	1
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	Sta	te	MARIA 31. Date filed (Mo.	ntn. Day, rear	)	A 32	( ) Pegistrar	301 s Signature	+	105	ITA	74	UR	GLE	NB	IRN	118	rid 21	061
	Registr			NOV 2	200	15 /	Mes.	s Signature	Sport	ME									

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg: No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3 Time of Death Month Day **Physician** MAMIE WALKER 17:20 NOVEMBER 15 2005 /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MULTICALE CENTER Keswick Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Yeer) Birthplace (State or Foreign Country) Funeral 10 M 201 Months Days Hours 218-32-5110 Yrs. Director Marvland Usual Residence of Decedent 10c. City, Town or Location 10a. Stete 10b. County 10d. Inside City Limits ss 1 and 2 should be filed within 72 hours after death with the Meryle of Health and Mentel Hygiene. It has not started that and Mentel Hygiene neturel, or Herns 23a or 28a-f show than traumatic event, the Medical Examiner must be notified. N/A Baltimore XX Yes 2 ☐ No Maryland Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3939 Roland Avenue Apt. 805 21211 USA 12. Was Decedent Ever in U,S. Armed Forces?
1 ☐ Yes ②XNo
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes XX No Specify: white Š Specify. 30XWidowed 4 □ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Farmer/ Farm manager Farming 6th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be fil.
Department of Health and Mentel He
Important: If item 27 is marked oth
any Injury or other traumatic even Be Jacob Baker Adelaide Spangler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Dorothy P. Deboard 2808 McComas Road White Hall, Maryland 21161 Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Moreland Memorial Park 11/18/05 Parkville, MD 4 ☐ Donation \_5 ☐ Other (Specify) 22. Name and Address of Facility
Burgee-Henss-Seitz Funeral Home, Inc.
3631 Falls Road Baltimore, Maryland 21211 21. Signatur Juneral Service Liver ee 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Physician Immediate Cause (Final disease or condition resulting in death) /Medical schemic Cardionyopath Examiner Due to (or as e consequence of) Examiner Hospital or Attanding Physician: The law requires that the death certificeta be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, by Physician/Medical Due to (or as a consequence of) Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. eral Director: After this cartificate has been signed by the efilled in by tha funeral director, page 2 should be detached 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ifficile 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy performed? 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medicai Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a

To the Funeral C

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiei (Check only one) To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1758303 November 17 2001 address of person who completed cause of death (Item 23e) (Type, Print)

ON CHANGES, M. (160) N. WOYLLS ST TOWSON, WO 7 CHARLES , m 4601 32. Pegistrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Manie MONKER

			1 - For State Registrar	State of I	Maryland		artment of		l Mental Hy	giene	5	37675
) }	Physici /Medio Examir	al	1. Decedent's Name (First, Middle	e Wi	200	401	4b, City, Town,	or Location of De	00	Day	2005 ty of Death	3. Time of Death [2:10 PM
7	Funeral Director		5. Social Security Number 216-34-6660 Usual Residence of Decedent	6. Sex 7. 1 ☐ M 2 🛣 F	Age (In yrs. Ia	ast birthday) Yrs.	If Under 1 Yea Months Days		rs. 8. Date of Bii in. (Month, Da	rth ay, Year) 1, 1938	9. Birthp Cour	place (State or Foreign ntry) MD
	e Maryland e-f ehow	ctor	MD 10b. County		10c. City	, Town or Lo		ALTIMORE			1	10d. Inside City Limits 1 X Yes 2 No
	3a or 28	I Dire	10e. Street and Number 3026 HARTFORD R	OAD			10f. Zip Code	21218		10g. Citizen of	What Cour	*
920	a within 72 hours after death with the Maryland liene. r then "netural", or iteme 23a or 28a-1 ehow the Modical Exeminant be mullied at	by Funeral Director	11. Marital Status  1 Never Married 2 Marrie 3 Xidowed 4 Divorced	12. Was Decede Armed Force at 1 Tyes 2 If Yes, Give Year or Date	s? <b>∑</b> No		Was Decedent of f Yes, specify Cu		(Specify Yes or No erto Rican, etc.)	o- 14 Ra Bla Speci	ace - Americ ack, White, ify:	
21215-0036	1 within 72 jene. rthen "nei	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12) 12		or 5+)	(Give	DO NOT use retir	during most of v	vorking	16b. Kind of I	Business/In	
Maryland	o a a a	To Be (	17. Father's Name (First, Middle, L HORA	ast) ACE SUBER				18. Mother's N	lame (First, Middle	e, Maiden Suma LLA REA	,	
	nd 2 should alth and 27 le m	•	19a. Informant's Name/Relationsh VALARIE WILLS D						Rural Route Numb	•	-	Code)
Baltimore,	Ø C - L		20a. Method of Disposition  1 ☑ Burial ☑ ☐ Cremation  4 ☐ Donation ✓ 5 ☐ Other (%)		te ce	metery, crei	sition (Name of matory or other pl	ace) MEMORIAI	Date 11/16/05	20c. Location		own, State
Balti	permit. Page Depertment Importent: if eny injury or once.		21. Signatur of Funeral Service	censee A	la	22	Name and Addi Miller": 1639 N	s Metropolita	an Chapel P.0 vay Baltimore	C. Mandan	4 21213	1
8760,	Physician and /Medical Examiner sthe parity is the parity in the parity is the parity in the parity	dical Examiner	23a. Payl 1. Enter the disease, or shock, or hear failufe. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	as a conseque	ence of):	er the mode of dy	ing, such as card	ac or respiratory a	irrest,		Approximate Interval Between Onset and Death
P.O. Box 6	death certif e attending od for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 MNo 9 ☐ Unknown		2 Fetal at time of de	death 3	Ectopic pregnan Other (specify)	су			ate of delive lonth	ery Day Year
Records, P.	v requires been sign should be	Completed by Pt	Part II. Other significant condition  ACU-te I  POST-08	ns contributing to death	but not resu	~1	ndertying cause g	iven in Part I.		Yes 2 □ No	3 🗆 Prob	he cause of death?  pably 4 □Unknown  posy findings available
al Re	The ate h page	e Comp						n (Cinabi	auto perio 1 ☐ Yes	psy ormed? 2 No	prior to cor death?	mpletion of cause of
Division of Vital	Attending Physician: Trideath. sctor: After this certifical by the funeral director, p	ToB	25. Was case referred to medical examiner?  1 Yes 2 No  27. Magner of Death  1 Natural 5 Pending investig			ER/Outpatier 28b. Time of Injury	28c. Inju	her: 4 Nursing	Home 5 Resi			v)
Divis	al or Attend after death I Director: d in by the	Certification;	3 Suicide 6 Could n 4 Homicide determi	ned   288. Place of	Injury - At hor etc. (Specify)	me, farm, str	eet, factory, office		28f. Location ( City or To	Street and Num wn, State)	ber or Rura	al Route Number,
	To the Hospital or Atte within 24 hours after de To the Funeral Direct completely filled in by th	edical C	29a. Certifier (Check only one)  Certifying  Certifying  Certifying	g Physician: To the be exeminer: On the basis and manner	s of examinati	vledge, deatl ion and/or in	n occurred at the vestigation, in my	ime, date and pla opinion, death oc	ce, and due to the curred at the time,	cause(s) and m date and place,	anner as st , and due to	lated. the cause(s)
	To th To th	Me	29b. Signature and title of vertifier	elt	M.	D	De	3386	2	29d. Date signe	2 C	Day, Year)
			DMITRIY V. P.	vho completed cause of	.D,		Print) 5601 M	D 2123	yen Bli	ra i Ka	.ltim	URL,
	Sta Registi		31. Date filed (Month, Day, Year) NOV 2	2 2005	strar's Signati	Ure A	carle					

Robert Clay Yon 05-7741 AJG Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

741	•	1 - For Unpend Item	State m 23a,pt.	of Marylan II,27 pe	d/Depa	artment of H	lealth and Deat <b>h</b> as	Mental Hy	giene ()	5 37676
Physicia		1. Decedent's Name (First, Middle Robert Clay You						2. Date of De Month Nove	mber 16	3. Time of Death , 2005 10:10AM
/Medica Examine		4a. Facility Name (If not institution Prince George's	n, give street and n			4b. City, Town, or Chever1			4c. Count	y of Death ce George's
Funeral Director		5. Social Security Number 251–80–4994	6. Sex 1 <b>3</b> M 2 ☐ F	7. Age (In yrs. 1	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		,1947	9. Birthplace (State or Foreign Country) South Carolina
with the Maryland as or 28a-f ehow	Director	10e. Street and Number	e George'	s	y, Town or Lo	10f. Zip Code	E			10d. Inside City Limits  1  Yes 2 No  What Country?
er death Items 23	by Funeral	2312 Brightsea  11. Marital Status  1 Never Married 2 Mar 3 Widowed 4 Divorced	12. Was De Armed I Tyes	icedent Ever in U. Forces? 2 ZMNo Give		2078 Was Decedent of H if Yes, specify Cuba 1 □ Yes 2 ☒ No	ispanic Origin?	(Specify Yes or N arto Rican, etc.)		ce - American Indian, ack, White, etc.
Maryland 21215-0036 nd 2 should be filed within 72 hours at lith and Mental Hygiane. 27 is marked other than "naturel", or riraumatic event, the Middical Exprin	Completed	15. Deceder (Specify only higher Elementary/Secondary (0-12)	- T	d) (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired ck Driver	during most of w d)	vorking	16b. Kind of E	Business/Industry
Maryland 2 should be file and Mental Hy is marked othe raumatic event,	To Be C	17. Father's Name (First, Middle, C.J. Yon					Wilhe.		Mays	
ore, Marylal set 1 and 2 should be of Health and Ment of Health are werked to ther traumatice		Nadean Yon Mu			2045	A Z Road			Carolina	
Page Page nent pant: hant; h		20a. Method of Disposition  1   Burial 2 □ Cremation  4 □ Donation 5 □ Other (S	Specify) 。	_	rch of	esition (Name of matory or other place Sod By Fait	h Cem. 11,	/22/05	North, S	outh Carolina
Balt permit. Depart Imports any Inji		21. Signature of Functional Service	Hum	M01113	9	2. Name and Addre	Street, 1	North, Sout	th Carolin	
	dical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due I	o (or as a consequence o (or a consequence o (or a consequence o (or a consequence o (or a consequence o (or a consequence o (or a consequence o (or a consequence o (or a consequence o (or a consequence o (or a consequence o (or a consequence o (or a consequence o (or a consequence o (or a consequ	uence of): uanca JI):	emorrhage	2			Onset and Death
9	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1□Live	outcome of pregna e birth 2 ∏Feta gnanl at time of d known	Ideath 3	Ectopic pregnancy Other (specify)				ate of delivery onth Day Year
Cords, P	ed by P	Part II. Other significant conditions are conditional conditions.				nderlying cause giv	en in Part I.		tobacco use cor Yes 2 □ No	ntribute to the cause of death?
Vital Records, sician: The law requires the certificate has been signe rector, page 2 should be created.	Complet							24a. Wa auto perf Yes	s an 24b. opsy formed? 2 \( \subseteq \text{No} \)	Were autopsy findings available prior to completion of cause of d all ?  1 No
of Vital F Physician: Th r this certificate rat director, pag	Be	25. Was case referred to medica examiner?  Yes 2 □ No	Hospital:	Manager 00	ER/Outpatie	nt 3□ DOA Oth	er	eath Check only		
After fune	ation; To	27. Manner of Death 1 X Natural 5 ☐ Pendi	28a. Da	y Inpatient 2 ☐ le of Injury onth, Day Year)	28b. Time o Injury	f 28c. Injur	4 🗀 Nursing	Home 5 ☐ Res 28d. Describe	how injury occu	
Division  To the Hospital or Attendi within 24 hours efter death. To the Funeral Director: A completely filled in by the ta	Certification:	3 Suicide 6 Could 4 Homicide determ	nined 286. Pla	ce of Injury - Al ho Iding, etc. (Specif	ome, farm, st	reet, factory, office		28f. Location City or To	(Street and Num own, State)	ber or Rural Route Number,
To the Hospital within 24 hours e To the Funeral I completely filled	Medical		ng Physician: To t Examinar: On the and ma			vestigation, in my o	pinion, death oc	curred at the time	, date and place	, and due to the cause(s)
To t withi To to	Z	29b. Signs fre and the of certific	en			0.C.M	e number • E •	A	29d. Date sign November	ed (Month, Day, Year) 17, 2005
		30. Name and address of person	lokell	use of death (Item	111 Pe	<sub>Print)</sub> enn Stree	t, Balti	imore, Ma	aryland	21201
Sta Registr		31. Date filed (Month, Day, Year		. Registrar's Signa	ature K. A.	act )				

DHMH 17 Rev 1/2001

ORIGINAL

			For	State of Maryland		artment of H		Mental	- San	000	37677
			Registrar  1. Decedent's Name (First, Middle, La	st)	Cer	uncate of t	Deam	2. Date			3. Time of Death
	Physicia /Medic		George Fr	ancis Zo	pF			Nove	1		- 4:30 PM
	Examin		4a. Facility Name (#L)not institution, giv	e street and number)	1	4b. City, Town, or	Location of Dea	th	4c.	County of Dea	th
	Funeral		5. Social Security Number 6. S		ast birthday)	If Under 1 Year	if Under 24 Hr	8. Date of	of Birth h, Day, Year)	9. Bir	NOR C thplace (State or Foreign
L	Director		25-16-4757	2 F 84	Yrs.	Months Days	Hours Mir		ber 24,1		aryland
	/land		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	cation					10d. Inside City Limits
	ith the Marylan or 28a-f show se notified at	ctor	mo Baltin	noke t	erre	Hall					1 ☐ Yes 2 No
ı	with th	Funeral Director	10e. Street and Number	0		10f. Zip Code	$\sim$ $l$		10g. Citi	izen of What C	ountry?
	ms 23	nerai	11. Marital Status	12. Was Decedent Ever in U.S	S. 13.	Was Decedent of H	ispanic Origin? (	Specify Yes	or No-	14. Race - Am	
2	or its		1 Never Married 2 Married	Armed Forces?  1 ⊠Yes 2 □ No If Yes, Give		r Yes, specify Cuba 1 □ Yes 2 No	In, Mexican, Pue Specify:	no nican, etc	:.)	Black, Whi	te, etc.
Ś	filed within 72 hours after deeth with the Maryland Hygiene. Hygiene. Ithe Medical Examinan mat be notified all ant, inc Medical Examinan mat be notified all	ed by	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's E	Year or Dates:	16a. Deced	dent's Usual Occup	ation		16b. Ki	ind of Business	Unite
2	thin 72 e. an "ne Medir	Completed	(Specify only highest grant (S		(Give	kind of work done of OO NOT use retired	during most of we	orking			
7 7	iled wi Hygien ther th nt, Ille		17. Father's Name (First, Middle, Last	)	TU <sub>7</sub>	erview	18. Mother's Na	me /First M	Str		- Maryland
	should be filed within nd Mentel Hygiene. marksd other than imatic svent, Ite M.	To Be	Corre Ed.	red Zen	<del>-</del>		Acre	C (2	ec in	(1)	del
	s 1 and 2 should be filed within 72 hours after deeth with the Maryla if Health and Mentel Hygiene. If Health and Mentel Hygiene and the standard standard other than "naturel", or itsms 23a or 28a-f sho other traumatic svent, its Medical Examinar must be notified at	-	19a. Informant's Name/Relationship (	Type, Print)	19b. Mailir	g Address (Street	and Number or F	Jural Route N			Zip Code)
ž Č	1 and Health am 27 thar to		Dopothy Zcap  20a. Method of Disposition	f-spase	9/03	Bowly sition (Name of	nerco	Date		MCRY ocation - City or	1000 21236
2	ages ant of h it: If its		1  Surial 2 □ Cremation 3 □ '4 □ Donation 5 □ Other (Speci	Removal from State	emetery, crer	natory or other place					
	permit. Pages Department of Important: If I any injury or one		21. Signature of Edneral Service Lice	9	. Livy	S Cemete Name and Addre	ss of Facility 2	Vans	Thape	OF M	eland, Marylan
٥	89 1 2 8		hennet	Compa	- 82	100 Hart	ord Ro	ad, Par	ekville	Mary	19nd 21234
			23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	one cause on each line.		1.5	1 2		ory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Arteniosc kno		ndiovascu	ilan Disi	ase			loyears
	Examiner		Sequentially list conditions,	b							
	nslt	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	ience ot):						
ב כ	be executed sicien end burial-transit		that initiated events resulting in death) Last	C. Due to (or as a consequ	ience of):						
00/00	cate be physici the bu	Physician/Medical		d							
מאמם	certifi nding use as	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnar					1:	23d. Date of de	livery
Ď.	The law requires that the death certificate ite has been signed by the ettending phys page 2 should be detached for use as the	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown		Ectopic pregnancy Other (specify)				Month	Day Year
	that the		Part II. Other significant conditions	contributing to death but not resu	Ilting in the u	nderlying cause giv	en in Part I.	239.	Did tobacco u	use contribute t	o the cause of death?
cords,	quires in sign uld be	ed by							1 ☐ Yes 2	□No 3□P	robably 4 Unknown
2	law re as bee 2 sho	Completed							Was an autopsy	prior to	utopsy findings available completion of cause of
								101	performed?	death?	
VII	reiclar s certif directo	o Be	25. Was case referred to medical examiner? 1 X Yes 2 □ No	Hospital: 1 Inpatient 2 I	ER/Outpatier	t 3 DOA Oth	er: 4 ☐ Nursing			6 □Other (Spe	ecify)
5	ng Phy fter thi	on: T	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o				ribe how injur		
IVISION	ttendi death. stor: A / the fu	ertification:	2 Accident investigation 3 Suicide 6 Could not t	De 290 Place of Injury - At ho	me farm str		Yes 2□No	28f. Locat	ion (Street an	d Number or F	ural Route Number.
2	al or A s after al Dirac	Certif	4 Homicide determined	building, etc. (Specify	)	oot, radiory, office			or Town, State		
	To the Hospital or Attending Physician: which 24 hours after deals as the deals To the Funaral Director: After this certifica completely filled in by the funeral director,	edical (		hysician: To the best of my know miner: On the basis of examinat and manner stated.							
	To the Within 1 To the comple	Med	29b. Signature and title of certifier	and married stated.		29c. Licens	e number		29d. Dat	te signed (Mon	th, Day, Year)
/	,	1	hitmatite M	Deputy		018	3667		Nove	ון ושמוו	,2005
X			30. Name and address of person who	completed cause of death (Item	23a) (Type.	Print) T. Luth	حالتيه	Mariel	3	21093	
	Sta	ate	31. Date filed (Month, Day, Year)	2. Registrar's Signat	ture Ange	le)	101.16	riary	avi C	0.01	
	Registr	rar	NOV 2 2 200	J Signa St.	AND THE REAL PROPERTY.						

			State of Maryland / Department of Health and Me  1- State Registrar  Certificate of Death		711115	37678
			Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medic		AUGUST A. Zachmeier	NOVEMBER	16,2005	11:25 P M
	Examin	er	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death		4c. County of Death	i
	Funeral		3, 1 - 2	8. Date of Birth (Month, Day,	BALTIMORE  9. Birth	nplace (State or Foreign untry)
*	Director		216.32.4287 12M 2UF 65 Yrs.	7.29	36 MA	Eyene
	ow st		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Location			10d. Inside City Limits
7	a-fah	ctor	MD HAPPORD FOREST HILL			1 ☐ Yes 2 🗹 No
gust	vith the	Dire	10e. Street and Number	10	g. Citizen of What Co	intry?
2,	na 23e	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spec	offy Yes or No-	14. Race - Amer	ican Indian,
2 9	within 72 hours after death with the Maryland ene. then "neturel", or Itama 23a or 28a-f ahow ta Medical Evant art must be notified at	/ Fun	1 Never Married 2 Married   Armed Forces?   If Yes, specify Cuban, Mexican, Puerto F	lican, etc.)	Black, White	
003	hours lural',	ed by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1	6b. Kind of Business/I	HITE
15	n "net	plete	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0·12)  College (1·4or 5+)	9	To the or business.	liddsity
212	giene giene er the	Completed	4 ENGINEER		SCHEROMEN	of Cost.
Maryland	12 should be filed within and Mental Hygiene. Tie marked other than "raumatic event, I'm Men	Be	17. Father's Name (First, Middle, Last)  18. Mother's Name  NULLIAM ZACHMEJER  EULA	(First, Middle, M	aiden Sumame)	
2 2	should nd Me mark mark	ို	WILLIAM LACHMEIE EULA  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural)	Route Number,	City or Town, State, Z	ïp Code)
- /=	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hyglene. I Health and Mental Hyglene. Item 27 ie marked other then "netural", or itema 23a or 28a-f ahow then traumatic event. It a Medical Event are notal for notified at		GINNI ZACHMEIGE, WIFE 1397 W. JARRETTSULL	JE RO. 1		4 MD 21050
1 J D	000-		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State	· 2005 -	Oc. Location - City or	rown, State
ı <u>ti</u>	permit. Pag Department Important: i eny injury o		4 Donation 5 Other (Specify)  21. Signature of Funeral Servica Licensee  22. Name and Address of Facility	To Forten	CHAPTLE	AR AR
Ва	permit. Departr import. eny inj		MOIZZO 3 NEWBET DE.	FORES		10 21050
6	1 Mar.		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.	respiratory arre	st,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition a. Nonhodg Kins Lymphima resulting in death)			Onset and Death  975
	/Medical Examiner		Due to (or as a consequence of):			
		ner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying			
<b>•</b>	ecuted and -transi	Examiner	Cause (Disease or injury that initiated events c. Due to (or as a consequence of):			
,60,	cate be executed physician and the burial-transit		Due to (of as a consequence of).		- 4	
	phy the	ledical	0.			
Вох	The law requires that the death certified has been signed by the attending tage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of deli Month	very Day Year
P.O. E	he dear the at	ysici	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (specify) 9 Unknown			24,
٥.	s that f ned by a detail	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
ords	w requires been sig should b		_ aute renal failure	1 🗆 Yes	s 2₽No 3□Pro	obably 4 Unknown
Division of Vital Records,	a law re has be e 2 sh	Completed	seps is	24a. Was an autopsy perform	24b. Were au prior to death?	topsy findings available completion of cause of
al F	n: The ficate or, pag	e Cor	25. Was case referred to medical 26. Place of Death	1 ☐ Yes 2	No 1 ☐ Yes	2 □ No
- Vit	ysicia is certi directo	To Be	examiner? Hospital: Other		nce 6 Other (Spec	eify)
n o	ng Ph Viter th Ineral		1 ☑ Matural 5 ☐ Pending (Month, Day Year) Injury Work?	8d. Describe how	w injury occurred	
isio	death.	Icati	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 2	8f. Location (Stre	eet and Number or Ru	ral Route Number.
Div	s after if Dire	Certification:	4 Homicide determined determined building, etc. (Specify)	City or Town,	State)	
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical (	29a. Certifier (Check only   Check  at the time, da	te and place, and due	to the cause(s)	
	o the o the omplet	Med	one) and manner stated.  29b. Signature and title of certifier 29c. License number	29	d. Date signed (Monti	ı, Day, Year)
	- s - ō		Alan/anul MD D25743	3	11-17	-05
4			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	. (-1-	Dall 1	10/21/201
$Q_{\ell}$	N SE SI	ate	and manner stated.  29b. Signature and title of certifier  Alau Luurel MD (1576 9 Worth Charlet 1981)  31. Date filed (Month, Day, Year)  NOV 2 2 2005  And manner stated.  29c. License number  29c. License number  29c. License number  10 2 5 7 7 3  25 7 7 3  25 7 7 3  26 8 7 8 9 8 9 8 9 8 9 8 9 8 9 8 9 8 9 8 9	J LT	partu	(4 4 204
1	Regist		NOV 2 2 2005			

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene or Free Print Index Print

		1	- State AMEND#8, perFH, Registrar	State of Marylar 11/09/2005, D	PS,MeC	artment of H	eaith and Me D <i>eath</i>	ental mygle Reg	2005	37679
	Physicia /Medica Examine		1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death
		al .	MILTON	J. ALSTON		# G' T		OCTOBER	Day Year 30,200	5 12:38P M
		er	4a. Facility Name (If not institution, give si Fort Washingto				Location of Death  Washingt	con		ce Georges
			5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days		B. Date of Birth (Month, Day, Y		thplace (State or Foreign buntry)
Ш	Director		5/9-64-51/8	M 2□F 56	Yrs.	Widiffilia Days	1,10013	Jan.14,	1049 W	ash. DC
	and		Usual Residence of Decedent  10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation				10d. Inside City Limits
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23e or 28e-f show any injury occiber traumatic avent, the Medical Examinar rust to conflict a sone.		DC		Wash	ington				1 Yes 2 □ No
			10e. Street and Number			10f. Zip Code		10g	. Citizen of What Co	•
		rai	1918 E Street,		140	1	002	if years as No	U.S.A	
Maryland 21215-0036		To Be Compieted by Fune	11. Marital Status  1  Never Married 2  Married  3  Widowed 4  Divorced	2. Was Decedent Ever in U Armed Forces? 1 Yes 22 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba  1 ☐ Yes 2 □XNo	ispanic Origin? (Spec in, Mexican, Puerto R Specify:	ican, etc.)	Black, Whi	
2-0			15. Decedent's Educ (Specify only highest grade	ation co <i>mpleted)</i>	16a. Dece (Give	dent's Usual Occup	ation during most of working 1)	g 16	b. Kind of Business	_
121			Elementary/Secondary (0-12)	College (1-4or 5+)			ounselor		DC Gen Hospit	
<b>d</b> 2			17. Father's Name (First, Middle, Last)				18. Mother's Name		iden Sumame)	
ılan			Robert Alston					ıreen J		
lary			19a. Informant's Name/Relationship (Type		19b. Maili	ng Address (Street	and Number or Plural	Route Number, C	City or Town, State,	Zip Code) 20011
	1 and 1ealth 1m 27		Stephanie Alsto	20b.	Place of Disp	osition (Name of	llum Pl.		oc. Location - City or	
nor	ages out of the state of the st		1 ☐8urial 2 ☐ Cremation 3 ☐ Re  '4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		matory or other place	ark 11/7,	/05	Landove	r. MD
Baltimore,	artmer ortant injury		21. Signature of Funeral Service License		2	2. Name and Addre	ss of Facility $$ $$ $$ $$ $$ $$	istin R	oyster 1	uneral am
m	Depar Impo		1947				nington,		0011	
	Physician /Medical Examiner as the prival-transit	ner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or poart failure. List only one cause on each line.  Approximate Interval Between Onset and Death							
25			Immediate Cause (Final disease or condition resulting in death)  Atherosclorotic Cardiovascular Heart Disease							
П			Due to (or as a consequence of):							
			Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury							
		Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	dilence of).					
68760,										
687	ificate g phys as the	edical		•						
P.O. Box	To tha Hospital or Attending Physician: The law requires that the death certi within 24 hours after death.  To the Funaral Diractor: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregr 1 □ Live birth 2 □ Fel 4 □ Pregnant at time of 9 □ Unknown	tal death 3	□Ectopic pregnancy □ Other (specify) _	4		23d. Date of de Month	elivery Day Year
			Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?							
ords		ted t	1 Yes 2 N						2 No 3 F	robably 4 dinknown
Records,		Completed						24a. Was an autopsy performe	prior to	utopsy findings available completion of cause of
al B							26. Place of Death	1 ☐ Yes 2	No 1□Ye	
of Vital		To Be	25. Was case referred to medical examiner?  1 ♥ Yes 2 □ No	ospital: 1 Inpatient 2	SER/Outpatie	ent 3□ DOA Oth	200		ice 6 Other (Sp	ecify)
of		T:u	27. Manner of Death  1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time Injury		ry at 2	8d. Describe how	v injury occurred	
sior		Certification:	2 Accident investigation	M 1 ☐ Yes 2 ☐ No		28f. Location (Street and Number or Rural Route Number,				
Division		ertifik	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, tarm, s cify)	treet, factory, office	2	City or Town,		anai nodia rombai,
		Medical Co	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
•	within To the To the Comp	Ž	29b. Signature and title of certifier	Aleta		29c. Licens			d. Date signed (Mor	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  SALVA DOV Sylvester, 3001 Hospital Drive, Clevels, MAY								MAY	/ANd	
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature								/		
	Regist	rar	NOV 0 4 200	5 Elevers L	r Age					

State of Maryland / Department of Health and Mental Hygiene

				,	Certificate of	Death	,	2005 Reg: No. U.5	3/680		
F		1. Decedent's Name (First, Middle	e, Last)				2. Date of Dea	ath	3. Time of Death		
	Physician /Medical	KAT	THLEEN VIRG	INIA A	HRENS		NOV.	Day Y			
1	Examiner	4a Facility Name (If not institution, give street end number)  4b. City, Town, or Location of Death  4c. County of Death									
		BROOKE GROVE	REHAB. & NI	JRSING		OLNEY		MONTG	OMERY		
	Funeral	5. Social Security Number	6. Sex 7. Ag	e (In yrs. last b	Months   Davs			h y, <i>Year</i> )	. Birthplace (State or Foreign Country)		
	Director	452-09-1419	1□ M 2\ <b>X</b> F	91	Yrs.		AUG. 4	, 1914	LOUISIANA		
	pu »	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location							10d. Inside City Limits		
	et et o								1 XYes 2 □ No		
	or 28e-fe perceitled	MD. MONTO	OMERY		ROCKVILLE 10f. Zip Code	<u> </u>		10g. Citizen of Who	at Country?		
	ath with the Merylan 23e or 28e-f ehow wat be notified at rai Director							-			
	s 23	13014 PAC	12. Was Decedent	Ever in U.S.		20853 Hispanic Origin? (	Specify Yes or No-		S.A. American Indian,		
	s after death v or items 23e aminer must	1 ☐ Never Married 2 ☐ Marr	Armed Forces?		13. Was Dacedent of I If Yes, specify Cub		rto Rican, etc.)	Black,	White, etc.		
3	er, or	3   Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates:		1 ☐ Yes 2 X No Specify:			WHITE		
Ş	n 72 hours after death with the Meryland "neturel", or items 23e or 28e-f show addal Examiner must be notitled at leted by Funeral Director	15. Deceden	t's Educetion	16	a. Decedent's Usual Occup	pation	orkina	16b. Kind of Busin	ness/Industry		
Ž	led within 72 ho ygiene. her then "netur ht, the Medical Completed	Elementary/Secondary (0-12)	st grade completed)  College (1-4or 5	i+)	(Give kind of work done life. DO NOT use retire	ed)	Ji Kili y				
7	gien.	12			SECRETARY				GOV'T.		
yland	be filed ntal Hygi nd other event, Be Co	17. Father's Name (First, Middle,	Last)			18. Mother's Na	me (First, Middle,	Maiden Sumame)			
<u>X</u>	Ment Ment To	LEROY	ROBERT CR	ISP		CATHI		MIRA ME			
Mar	2 shoul and Miss mark	19a. Informant's Name/Relations	hip (Type, Print)		b. Mailing Addrass (Stree						
	and ealth n 27 ner tr	ROBERT W. AI	IRENS/SON		13014 PACIFI	IC AVE.,					
saltimore,	Pages 1 an ment of Heamt: If Item ury or othe	20a. Method of Disposition 1 ☐ Burial 2 反 Cremation	3 □Removal from State	cemet	of Disposition (Name of ery, crematory or other pla		Date	20c. Location - Ci	ty or rown, State		
	iii. Pages 1 and 2 should art ment of Health and Mer zrlant: if Item 27 is merke injury or other treumatic	4 □ Donation 5 □ Other (S	pecify)	СНА	MBERS CREMAT		11-3-05	RIVERD	ALE, MD.		
g	permit Deper Impor eny in	21. Signature of Funeral Service	22. Name and Address of Facility CHAMBERS FUNERAL HOME & CREMATORIU 5801 CLEVELAND AVE., RIVERDALE, MD								
		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caused only one cause on each li	the death. Do					Approximate Interval Between		
1	Physician	Onset and De									
	Medical . Examiner	disease or condition a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE resulting in death)									
		,,		Due to (or as a	a consequence of):						
	executed in and iel-transit		b	Due to for on	oonnoguonee of):						
	execunation and instructions in a secunation and instructions in a security and instruction and instructions in a security and instruction and instructions in a security and instruction	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events  Due to (or es a consequence of):  c									
P8/P0	ficate be of physicial set the buni										
_		resulting in death) Last									
ô n	ss that the death cer igned by the attendin be detached for use by Physician/N	<u> </u>									
o.	the shed	Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of dea			
7.	ed by detay						1 1	1 ☐ Yea 🌠 No 3 ☐ Probably 4 ☐ Unknown			
ď,	isigne Id be d	24a.						24a. Was an autopsy 24b. Were autopsy			
Sord	w require been sig should b							rmed?	available prior to completion of cause of death?		
ĕ	2 S B						103	for 2 <b>K</b> No	1 Yes 2 No		
<u></u>	certificate h rector, page	25. Was case referred to medica				26 Place of De	eath (Check only o		10 165 20 140		
VITA		examiner?	Hospital:	on• 2□ EB/0	Outpatient 3 DOA Ot	her:			(Specify)		
Ö	E E =	1 Inpatient 2 EH/Outpatient 3 DOA 4 EH/Outpatient						me 5 ☐ Residence 6 ☐ Other (Specify)  28d. Describe how injury occurred			
	Attending or death. ector: After by the fune tification	1 X Natural 5 ☐ Pendir 2 ☐ Accident investi	9	(Month, Day Year) Injury Work?  M 1 ☐ Yes 2 ☐ No							
DIVISION	tal or Attending P rs efter death. al Director: After ti led in by the funers Certification:	3 ☐ Suicide 6 ☐ Could	mined 286. Place of injury - At nome, farm, street, factory, onice			28f. Location (Street and Number or Rural Route Number, City or Town, State)					
ב	s effe ed in		building, etc. (Specify)								
	To the Hospital or A within 24 hours efter To the Funeral Dire completely filled in the Medical Certi	29a. Certifier  (Check only one)  12 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated.									
	o the vithin fo the comple	29b. Signature and the of certifie		,	29c. Licen	se number		29d. Date signed (	Month, Day, Yeer)		
	7	D08381 NOV. 3,						. 2005			
•	V	30. Name and andress of person	who completed cause of c	leath (Item 23a					20832		
		BENJA				INCE PHIL	LIP DR. S	<b>UITE 209</b>	, OLNEY, MD.		
	State	31. Date filed (Month, Day, Year,		ar's Signature	Souls						
	Registrar	NOV 0 4	ZUUJ CUUL	1 88	The same of the sa						

DHMH 16 Rev 6/95

			1 - For State Registrar	State of	Marylan		artment of F rtificate of		nd Mental Hy	/giene	37681
	Physici	an	1. Decedent's Name (First, Middle,	Last)					2. Date of D Month		3. Time of Death
	/Medic		Awni	Aziz		Ayou				1,2005	11:43a M
7	Examin	er	4a. Facility Name (If not institution,	•			4b. City, Town, o		Death	4c. County of	
			Shady Grove 2  5. Social Security Number		. Age (In yrs.	last hirthday)	Rockv		4 Hrs. 8 Date of B		gomery
	Funeral Director		579-58-0406	15€2 M 2 □ F	67		Months Days	Hours	Min. (Month, D	ay, Year)	B. Birthplace (State or Foreign Country)  Montgomery
	D .		Usual Residence of Decedent  10a. State 10b. County	· · · · · · · · · · · · · · · · · · ·	100 Cit	tv. Town or Lo					
	72 hours after death with the Maryland naturel; or items 23a or 28a-f show iteal Examirser must be natified at	ō	MD Montgo	omery			rsburg				10d. Inside City Limits 1 ☐ Yes 2X No
	28a-	Jec.	10e. Street and Number				10f. Zip Code	-		10g. Citizen of Wh	at Country?
	N with	Funeral Director	466 West Deer	Park R	oad			877			estine
	deat	ner	11. Marital Status	12. Was Deced	lent Ever in U	.S. 13.	Was Decedent of H	Hispanic Orig	in? (Specify Yes or N Pu <i>e</i> rto Rican, etc.)	o- 14. Race -	American Indian, White, etc.
36	or it	by Fu	1 Never Married 2 Marrie	ld 1 ☐ Yes 2	₽₩No		1 ☐ Yes 2√☐ No		, ,	Specify:	White
Maryland 21215-0036	72 hours naturel',	ed b	3 ☐ Widowed 4 🔯 Divorced	Year or Date	les:	16a Dece	dent's Usual Occup	nation		16b. Kind of Busi	
7.	d within 72 ho jiene. r than "netur I're Modical	plet	(Specify only highest Elementary/Secondary (0-12)	grade completed)	40.5.\	(Give	kind of work done DO NOT use retire	during most	of working	TOD, KING OF BUSI	nosa muusii y
212		Completed	88	College (1-	401 5+)	Rı	ıg Cleai	ning		Rug Cl	eaning Co.
Б	be filed ital Hygi of other event, I	Be	17. Father's Name (First, Middle, L	ast)					's Name (First, Middle		
<u>Y</u>	should by	은	Aziz Ayoub						eeleh Fa		
Mar	d 2 sho h and 7 ie mu traum		19a. Informant's Name/Relationsh								tate, Zip Code)37902
	as 1 and 2 should of Health and Men litem 27 is marks		Pete Ayoub/So 20a. Method of Disposition	)[[	20b. F	Place of Dispo	sition (Name of	- 1	Date Kn	20c. Location - Ci	Tennessee
OT.	Pages nent of I		1 XBurial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (Sp				natory or other pla al Mem. I		1/04/05		hurch, VA.
Baltimore,	当者を		21. Signatur	1-1-4							
ä	Department of the partment of		Mily Old	ned de		92	241 Coli	imbia	Blvd.Si	kal SERV lver Spr	ICE,P.A. ing,Md20910
i i			23a. Part1. Enter the disease, or of shock, or heart failure. List of	complications that ca nly one cause on ea	used the deat ch line.						Approximate Interval Between
	Pn <del>ysicia</del> n		Immediate Cause (Final disease or condition	ANO	XIC E	NCE	PHA COL	DATNO	4		Onset and Death
	/Medical Examiner		resulting in death)	Due to (o	r as a conseq	juence of):	. 1	~ ^^ -			1 0
1	LXGIIIII C	e.	Sequentially list conditions,	Due to (o	r as a conseq	DIAY	///	MRC	TION	4.4	uny
	ted nsit	ulue	Suggestian, list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	200 10 (0	1 43 A CO11364	derice ory.					
Ć.	be executed sician and burial-transit	Examln	that initiated events resulting in death) Last	c Due to (o	r as a conseq	uence of):			· · · · · · · · · · · · · · · · · · ·		
8760,	ate be hysicia the bur	cal		d							
9	ing ph	Medi	IF FEMALE:								
Вох	eath certifica attending ph i for use as th	ian/	23b. Was decedent pregnant in the past 12 months?		th 2 🗌 Festa	ıldeath 3□	Ectopic pregnanc	у		23d. Date of Month	
0	at the de by the a tached f	Physician/M	1 □ Yes 2 □ No 9 □ Unknown	4∟Pregna 9□Unknov	nt at time of d vn	leath 5	Other (specify) _				.,
<b>a</b>	ge g		Part II. Dther significant condition	s contributing to dea	ath but not res	sulting in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco usa contrib	ute to the cause of death?
rds	n sign	ed by							1_	Yes 2 □ No 3	Probably 4 □Unknown
000	aw requir as been si 2 should	plete							24a. Wa		ore autopsy findings available
Vital Records,	The lay	Completed							auto perf 1 ☐ Yes	ormed?dea	or to completion of cause of ath?  Yes 22 No
/ita	icien: T certificat ector, p	Be (	25. Was case referred to medical examiner?						of Death (Check only		
of \	Physicien: this certific ral director,	၉	1 Yes 2 No			ER/Outpatier			sing Home 5 Res		
nc On (	fter	lon	27. Manner of Death  1. Natural 5 Pending		Day Year)	28b. Time of Injury	Wo	yat rk? Yes 2.∐N		how injury occurred	
Division	Attending r death. ector: After you the fune	ertification:	2 Accident investigation of Could not determine	ot be	of Injury - At h	ome, farm, str	eet, factory, office	163 2 11		(Street and Number	or Rural Route Number,
Ω	i die	erti	4  Homicide determine	buildin	g, etc. (Specil	ý)	Ton nationy, office			wn, State)	
	Hospit 4 hour Funera ety fille	edical C	29a. Certifier 1 Certifying (Check only one)	Physician: To the taxaminer: On the bas	sis of examina	owledge, deat ation and/or in	h occurred at the til vestigation, in my o	me, date and opinion, death	place, and due to the occurred at the time	cause(s) and mann date and place, and	er as stated. d due to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier				29c. Licens	se number		29d. Date signed (	Month, Day, Year)
) .	> - 0		Mul	TIT P.KL	RUNG	ica. w	0 14	6187		NOVEMB	ER 1 2005
	1		30. Name and address of person w	no completed cause	of death (Iter	n 23a) (Type,	Print)			V	
			AUIT P. KURU	VILLA, M.	0, 11	125 6	COCKVILL	·É PI	KE, #208	ROCKY	ILLE, MD 2085
	Sta Registi		31. Date filed (Month, Day, Year)	32. Re	gistrar's Signa	ature	de		,		Month, Day, Year) ER 1 2005. ILLE, MD 2085.
	riegisti	CII	MOV U 4	LUUJ	19.1 19.3						

	•	State of Maryland / Department   State of Maryland / S	artment of Health and I rtificate of Death		2005	37682
		Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
Physicia		John Lawrence Avery		October	Day Year 31, 2005	10:12P M
/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deat	
	•	Holy Cross Hospital	Silver Spring		Montgor	nerv
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.		9. Birt	thplace (State or Foreign
Director		216-46-2153 87		Apr. 19,		nington,DC
and and	-	Usual Residence of Decedent         10a. State         10b. County         10c. City, Town or Loc	cation			10d. Inside City Limits
Manyl f eho	0	Y 1 1 Y				1 ☐ Yes 2 ☐ No
288	Director	Maryland Montgomery Silver S	10f. Zip Code	100	. Citizen of What Co	puntry?
3a or		#316 3142 Gracefield Road, Madison Green	20904		TIC A	
death ms 2	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (S	pecity Yes or No-	USA 14. Race - Ame	
or its	Ē	1 Never Married 2 Married 1 Yes 2 No	If Yes, specify Cuban, Mexican, Puert	o Hican, etc.)	Black, Whit	e, etc.
ours Frail.	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates: WW II	1 ☐ Yes 2 ☐ No Specify:		Specify:	Mhite
72 h	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of wor	rking 16	b. Kind of Business/	Industry
within han	m m	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)			
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d be i	o Be			_	,	•
should Me mark	ဥ	Lawrence Avery  19a. Informant's Name/Relationship (Type, Print)  19b. Mailin	Marie ng Address (Street and Number or Ru	Drury ural Route Number, 0	City or Town, State, 2	Zip Code)
ING 1th ar 1th ar 1trau		Doris_BAvery Wife 8142 (	Gracefield Road, Silver S	Madison G	reen #316	101
S 1 ar				Date 20	c. Location - City or	Town, State
ages onto		1☑ Burial 2 □ Cremation 3 □ Removal from State  `4 □ Donation 5 □ Other (Specify)  Cemet	natory or other place)	/ 2005 da	leram Camba	. Manutani
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if tien 27 is marked other than "heturer", or itams 23a or 28a-f show any injury or other traumatic event, the Marilest Examinations and injury or other traumatic event, the Marilest Examinations and injury or other traumatic event, the Marilest Examinations and injury or other traumatic event, the Marilest Examinations are allowed.		21. Signature of Funeral Service Licensee	2. Name and Address of Facility		- 2	ng,Maryland
Pagin Pag		Being W. Silis	cancis J. Collins OU University Blv	Funeral H	iome, Inc.	MD 20901
120		23a. Part 1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.	er the mode of dying, such as cardiac	or respiratory arres	i,	Approximate Interval Between
Physician		Immediate Cause (Final	•		1	Onset and Death
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D =	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying				
and trans	Examiner	Cause (Disease or injury that initiated events c.				
w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	<u> </u>	resulting in death) Last Due to (or as a consequence of):				
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o certify anding I use as	w	IF FEMALE: 23c. If yes, outcome of pregnancy			OZ d Dave of del	
atten for u	cian	in the past 12 months?	Ectopic pregnancy Other (specify)		23d. Date of del Month	Day Year
the d	Physician/M	1 Yes 2 No 9 Unknown				
that the ded by deta		Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did toba	cco use contribute to	the cause of death?
us, puires ti n signe	d by			1 ☐ Yes	2 □ No 3 □ Pr	robably 4 Minknown
w required should should	iete			24a. Was an	24b. Were at	utopsy findings available
VII.al neC	Completed			autopsy	d? death?	completion of cause of
an: T	O	25. Was case referred to medical	26 Place of Dea	1 Yes 2€ ath (Check only one)	No 1 ☐ Yes	2 No
yslci s cer direct	OB	examiner? 1 ☐ Yes 2 🕱 No	Other	lome 5 ☐ Residen	ce 6 ∏Other (Spe	cifv)
g Phy ger this	n; T	27. Manner of Death 28a. Date of Injury 28b. Time o		28d. Describe how		
ath.	atio	2 Accident investigation	M 1 ☐ Yes 2 ☐ No			
r Atte	ertification;	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, stee building, etc. (Specify)	eet, factory, office	28f. Location (Stre City or Town,	et and Number or Ru State)	ural Route Number.
res aft	O					
To the Hospitel or Attending Physicien: The law requires that the death certif within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	edical	29a. Certifier  (Check only one)  M☐ Certifying Physician: To the best of my knowledge, death of the basis of examination and/or in and manner stated.	n occurred at the time, date and place vestigation, in my opinion, death occu	e, and due to the cau- irred at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
o the ithin ; o the omple	Mec	29b. Signature and title of certifier	29c. License number	290	I. Date signed (Monti	h, Day, Year)
⊢ \$ ⊢ ō		· CYMMTauxax	DR 0063570	9	11/2/20	005
.2 11		30. Name and address of person who completed cause of death (Item 23a) (Type.		1	RD.	
12+1		MARIA JERAWINE M. TAYAG	Print) 1500 FORES SILVER SPRI	NG IMD	•	
Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	certe		-	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** FLORA 30, 2005 october /Medical Baltimore City

Baltimore City

Allower I Year If Under 24 Hrs. 8. Date of Birth
Min. Min. Month, Day, 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore The Johns Hopkins Hospital Birthplace (State or Foreign Country)
 KY 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 M 2 XF Yrs. October 10,1924 407-20-8029 81 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ir than "natural", or items 23a or 28a-f show The Medical Examinar must be notified at 1 Yes 2 No Director Harlan Evarts 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code be filed withIn 72 hours after death with 40828 USA 104 Knox Street by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify: 3 ☐ Widowed 4 ☑ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Heath and Mental Hygiant Important: if item 27 is marked other than any injury or other traumatic most. Elementary/Secondary (0-12) College (1-4or 5+) 12 Realtor Real Estate 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Wiley Ford Laura Amy Saunders 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 792 Lorraine Drive, Warrington, PA Billie La Reddola 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 11-03-2005 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Rising Sun, MD R.T. Foard Funeral Home, P.A. 4 Donation 5 Other (Specify) 22. Name and Address of Facility R.T. Fourd Funeral Home, P.A. 21. Signature of Funeral Service Licenses 111 S. Queen St., Rising Sun, MD uch and 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one zavise on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Respiratory Failure Physician disease or condition resulting in death) /Medical 4 months Examiner small cell Lung cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) signed by the at d be detached fo ☐Yes 2☐No 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Nnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page deatn? 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ Vo Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Dopatient 2 ER/Outpatient 3□ DOA P 27. Manner of Death 1 [A Natural 28c. Injury at Work? Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Medical Certification: After 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident neral Director: / filled in by the f 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 24 the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 101 dally Moselly, Medical Doctor Res-000 address of person who completed cause of death (Item 23a) (Type, Print) October 30, 2005 Kendal Moseley, The Johns Hopkins Hospital, 600 North Wolfe Street, Maryland 21231
31. Date filed (Month, Day Year) 2005
Registrar's Signature for Signature

DHMH 17 Rev 1/2001

State Registrar

	stric .	- State Registrar Amend Item	#5 Per I	iryland / Depa nf G855 <b>G9</b>				Reg.	2 U U U	37684
Physicia	an	1. Decedent's Name (First, Middle, Las							Day Year	3. Time of Death
/Medic	al		RAEZ AGU	ILERA				NOV 5	2005	12:20 A M
Examin	er	4a. Facility Name (If not institution, give		TAMED	4b. City, To	own, or Location of D	eath		4c. County of Deat	
		NATIONAL NAVAL		ENTER  (In yrs. last birthday)	If Under 1	BETHESDA Year If Under 24	Hrs. a	Date of Birth	MONTGO	
Funeral Director		5. Social Security Number 6. Security Number 12 12 12 13 13 13 15 15 15 15 15 15 15 15 15 15 15 15 15	x ]M 2□F	76 Yrs.			MA	Date of Birth Month, Day, Ye AY 18, 1	l 929 NE	hplace (State or Foreign buntry) W YORK
and w		10a. State 10b. County		10c. City, Town or Le	ocation					10d. Inside City Limits
Mary	to	MD. MONTGOME	RY		ROCKV	ILLE				1 XYes 2 □ No
r 28s	Funeral Director	10e. Street and Number			10f. Zip C	ode		10g.	Citizen of What Co	ountry?
th wit	a D	5901 MONTROSE	RD. #S10	8	İ	20852			U.S.	Α.
dea	ner	11. Marital Status	12. Was Decedent I Amed Forces?	Ever in U.S. 13.	Was Decede	nt of Hispanic Origin Cuban, Mexican, P	? (Specify uerto Rica	Yes or No-	14. Race - Ame Black, Whit	
s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If Health and Mental Hygiene. Other traumatic event, the Madical Examinar must be notified at	þ	1 ☐ Never Married 2 🛣 Married 3 ☐ Widowed 4 ☐ Divorced	1 ∑XYes 2 ☐ N If Yes, Give Year or Dates:	1948 <b>–</b> 1968	1 🗓 Yes 2 [	☐ No Specify: _	UBAN		Specify:	HITE
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hould the district market	P P	MARIO  19a. Informant's Name/Relationship (7)		UILERA 19b. Mail	ing Address /	Street and Number of	-	RANCISCA		Zip Code)
d 2 sho th and th and the my traum		KAREN A. AGUILI				OSE RD. #				
1 and 1 Health Health 27 other tr		20a. Method of Disposition	IKA/ WITE	20b. Place of Disp	osition (Name	of	Date		c. Location - City or	
ages intof it: if it		1 Burial 2 Cremation 3 4 Donation 5 Other (Specify		cemetery, cre	•		-16-2	2005 T	TTTEDDATE	MD
permit. Pages 1 ar Department of Hea importent: if item any injury or othe		21. Signature of Funeral Service Licen		CHAMBERS					RIVERDALE	•
permit. P Departm Importar any injur		10/11/Chr	mhunas	M00091 5	CHAMBER S801 CI	Address of Facility S FUNERAL EVELAND A	HOMI VE	E & CREN RIVERDA	MATORIUM, ALE. MD.	P.A. 20737
Physician /Medical Examiner	er	23a. Part1. Enter the disease, or composed in the shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, and the same of th	a	SMALL BOW a consequence of):			rdiac or re	spiratory arrest,		Approximate Interval Between Onset and Death
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VICAL THE SAW requires that sicien. The saw requires that certificate has been signed the rector, page 2 should be delt	d by P	Part II. Other significant conditions of	ontributing to death b	ut not resulting in the	underlying ca	use given in Part I.				o the cause of death? robably 4 Unknow
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The lav	E O						_	autopsy performed 1X Yes 2	d?   death?	completion of cause of
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ysician: ysician: is certific director,	ToB	examiner? 1 ☐ Yes 2X No	Hospital: 1 Xinpatie	ent 2 ER/Outpatie	ent 3 DO	Othor			e 6 ☐Other (Spe	ecify)
ng Phy iter thi		27. Manner of Death	28a. Date of Inju (Month, Da		of 28	c. Injury at Work?		. Describe how		,
SIOI tendir fleath. for: Al	Certification:	1 Natural 5 Pending investigation 3 Suicide 6 Could not b determined	28e. Place of Injuding, et	ury - At home, farm, s c. (Specify)	M street, factory,	1 ☐ Yes 2 ☐ No	28f.	City or Town, S	State)	tural Route Number,
To the Hospital or Al within 24 hours effer or To the Euneral Direc completely filled in by	Medicai C	29a. Certifier Certifying Phase (Check only one) Certifying Phase 2 Medical Example (Check only one)	ysician: To the best niner: On the basis o and manner st	of my knowledge, dea f examination and/or i ated.	ath occurred a investigation,	t the time, date and and my opinion, death	olace, and	due to the caus at the time, date	se(s) and manner a and place, and du	s stated. e to the cause(s)
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		30. Name and a dress of person who	completed cause of	leath (Item 23a) (Type	e, Print)	NATIONAL	NAV	AL MEDI	CAL CENTE	
10.00		TAMARA W. KINDEL				BETHESDA	A MD	20889-5	600	
JU										

I			1. State	epartment of Health and Mental F Certificate of Death	2005 3/605
7			Decedent's Name (First, Middle, Last)	2. Date of	
	Physici /Medic		THEODORE E. BAIR, IR.	Novem	nber 5 2005 0054 M
E.	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
	F	A.	3203 Route 273  5. Social Security Number 6. Sex 7. Age (In yrs. last birth	Elkton    day   Il Under 1 Year   If Under 24 Hrs.   8. Date of	Cecil  Birth  9. Birthplace (State or Foreign
4	Funeral Director		111 0 00 00 00 000 000	rs. Months Days Hours Min. (Month,	7-81 LANCASIER PA
	and w		Usual Residence of Decedent  10a, State 10b, County 10c, City, Town	or Location	10d. Inside City Limits
	Maryl	ţō	PA LANCASTER NEW	PROVIDENCE	1 ☐ Yes 2 No
	or 28s	Olrec	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	a 23a	by Funeral Director	729 HOLLOW ROAD  11 Marital Status  12. Was Decedent Ever in U.S.	17/560	r No- 14. Race - American Indian,
(0	r item	Fune	Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	Black, White, etc.
5-0036	72 hours after death with the Maryland natural; or Itema 23a or 28a-f ehow Beal Examinar must be notified at	d by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 SNo Specify:	Specify: White
215-(	in 72 h	Completed	(Specify only highest grade completed)	Decedent's Usual Occupation 'Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
212	d within giene. er than "	omo	Elementary/Secondary (0-12) College (1-4or 5+)	RY WALL HANGER	CONSTRUCTION
pu	iges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene.  If item 27 is marked other than "natural", or itema 23a or 28a-f show or other traumatic event, the Madical Examinar must be notified at	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Mid	Α - Α
Maryland	hould by Ment marked marked marked	6	THEO DORE E. BAIR, SR 19a, Informant's Name/Relationship (Type, Print)	Mailing Address (Street and Number or Rural Route Nu	HORNBERGER  imber City or Town, State Zio Code) 175/60
	1 and 2 sho Health and em 27 ie ma		TAMMY S. GEBHART 7	29 HOLLOIN ROAD 1	NEW PROVIDENCE PA
Baltimore,	permit. Pages 1 ar Department of Hea mportant: if Item Iny injury or othe DDCE:		20a. Method of Disposition  1	Disposition (Name of Date prethatory or other place)	20c. Location - City or Town, State
ţ	Part Part		4 □Donation 5 □Other (Specify)	NON TE CON NOV 9, 0	
Bal	permit. Pa Departmen Important any injury		21. Signifure of Funeral Service Libensey	Reynolds Funeral Home	QUARRYVILLE PA 1750
			23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.		ry arrest, Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition MDCT) DUE 1	LURIES	Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequence of	):	
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8760,	cate be executed physicien and the burial-transit	al Ex	resulting in death) Last Due to (or as a consequence of	):	
687	ficate phys as the	edical	d.		
Box	death certific e attending p id for use as	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death	3 ☐Ectopic pregnancy	23d. Date of delivery
_	0 0 2	ysici	in the past 12 months?  1   Yes   2   No   9   Unknown   9   Unknown	5 Other (specify)	Month Day Year
, P.O.	requires that the de een signed by the a nould be detached t	y Ph	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I. 23e. C	Did tobacco use contribute to the cause of death?
Records,	w requires been sign should be	ed b		1	☐ Yes 2 No 3 Probably 4 ☐ Unknown
ecc	as b	nplet		a	Vas an 24b. Were autopsy findings available prior to completion of cause of
a H	Page Page			1 <b>0</b> /e	efformed? deaty\? es 2 □ No ✓ Yes 2 □ No
Vital		To Be	25. Was case referred to medical examiner?  1 □ XYes 2 □ No  Hospital: 1 □ Inpatient 2 □ ER/Outp	26. Place of Death Check or Death 3 DOA Other: 4 Nursing Home 5 F	Residence 6 (20ther (Specify) Scene
Division of	ng Phys ter this neral di		27. Manner of Death 28a. Date of Injury 28b. Ti		ibe how injury occurred
Sio	tendii Jeath. tor: A the fu	catio	2 Accident investigation 11-5-5	BGAM 10 Yes 20 No Dilling	n OF CAR ROLLED OVER, FUEL
Dİ	after after Direct In by	Certification:	4 Homicide determined 28e. Place of Injury - At home, Iarr building, etc. (Specify)		on (Street and Number or Rural Route Number, Town, State)
	ospita hours unerel	calc	29a. Certifier 1 Certifying Physician: To the best of my knowledge, (Check only 2 Medical Examiner: On the basis of examination and	death occurred at the time, date and place, and due to	the cause(s) and manner as stated.
	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medical	one) and manner stated.  29b. Signature and title of certifier ,	29c. License number	29d. Date signed (Month, Day, Year)
	5 × 5 S		290. Signature and the of certains.	OCME	November, 5, 2005
	.7		30. Name and address of person who completed cause of death (Item 23a) (7	Type, Print)	
	~		MARGORITO D. 1 Corore	111 Penn Street Bal	ltimore, Maryland 21201
	Sta Regist		31. Date liled (Month, Day, Year)  NOV 0 9 2005	is a second second	
			MAN A STAND LINE TO THE		

	Amend	E E	rem # 20, a,b,c <sub>Si</sub>	<b>e or Print in</b> ate of Maryla						37686
_			State Registrar Cecil Co.	11/09/05	rj√Ce	rtificate of	Death	Reg	J. No.	3/000
	Physici /Medic		Decedent's Name (First, Middle, Last)     Floyd Brackins					2. Date of Death Month October	Day Year	3. Time of Death  2:56 PM M
	Examin		4a. Facility Name (If not institution, give stree	t and number)		4b. City, Town,	or Location of Death		4c. County of De	
	ž.		Harford Memorial Hos				de Grace		Harf	
	Funeral Director		5. Social Security Number 6. Sex 1 ☑ M		s. last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day, 1 Sept 1,	<sup>9. B</sup> 1950 Ma:	pthplace (State or Foreign Country) ryland
	and		Usual Residence of Decedent  10a. State 10b. County	10c. C	City, Town or Lo	ocation				10d. Inside City Limits
	Maryl f sho	ō	MD Cecil		Conow	ingo				1 ☐ Yes 2 ☐ No
	death with the Maryland ms 23a or 28a-f show frust be nutified at	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What C	
7	th wit	ai D	1394 Liberty Grove	Road		21	918		IISA	
3	er dea	Funeral	11. Marital Status	Vas Decedent Ever in Immed Forces?	U.S. 13.	Was Decedent of If Yes, specify Cub	Hispanic Origin? (Sp pan, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh	
36	ours after death with the Maryla ral', or Hems 23a or 28a-f shov Examinatival be notified at		1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	√∑Yes 2 ∐No "Yes, Give ′ear or Dates:		1 ☐ Yes 21 No	Specify:		Specify:	white
105 21,57 Maryland 21215-0036	72 hours after death w "natural", or Items 23a olest Examiliar is ust b	Completed by	15. Decedent's Education	n	16a. Dece	dent's Usual Occu	pation	. 10	6b. Kind of Busines	s/Industry
215	ithin 7 ne.	nple	(Specify only highest grade con Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire		ing		
121	fled w tygier her th	Cor	12 17. Father's Name (First, Middle, Last)	0		labor	T	e (First, Middle, M	mason	nery
anc	d be findal Had of	Be c	James Spencer Brac	kine				nny Clark		
N E	should nd Me mark imation	2	19a. Informant's Name/Relationship (Type,		19b. Maili	ng Address (Stree	t and Number or Run			Zip Code)
	alth a alth a 27 is		Jenny Brackins/moth	er			Grove Ro			
10   30   05 Baltimore, Mary	of He of He fitem		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Remo	20b.	Place of Dispo cemetery, cre	osition (Name of matory or other pla	ace)	Date 20	Oc. Location - City o	r Town, State
OF	Pag ment tant: I		*4 □ Donation 5 → Other (Specify) = 1	n state	R.A. F	erris 8	co. 11	/09/05_	West Ch	nester, PA
Balt	permit. Pages I and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 is markad other than "natur any injury or other traumatic event, it e Mcdical once.		21. Ronald S. Wac	e presto	r S	2. Name and Addr ate Anat	ess of Facility Comy Board	655 W. 1	Baltimore	Street
			23a. Part1. Enter the disease, or complication shock or heart failure. List only one care	ins that caused the dea	ath. Do not en	altimore, ter the mode of dy	MD = 2120 ing, such as 5a20 ac	Tritza 20	Havr	eral HomeP.  e AGGEXIM GET a CE Interval Between MD
	Physician		Immediate Cause (Final	use on each line.	andh.					Interval Between IMD Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a conse	equence of):	y eyer	nos aux	Remo	uniye	
	Examiner		Sequentially list conditions. b. —	Pals	noxan	ry em	bolism	7		
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	equence of):					
	be executed sician and burial-transit	хап	that initiated events c resulting in death) Last	Due to (or as a conse	equence of):					
5	e be e	ro .								
F 687	death certificate I e attending physi id for use as the b	by Physician/Medic								
30 E	ath cei Itendii or use	an/N	in the past 12 months?	f yes, outcome of pregi □Live birth 2□Fe	tal death 3[	∃Ectopic pregnand	су		23d. Date of do	elivery Day Year
0.	the air	ysici	1 Ves 2 No	I□Pregnant at time of I□Unknown	death 5[	Other (specify)			Month	Day Feat
Ø 9.	that the by detact	V Ph	Part II. Other significant conditions contrib	itigg to death but not re	sulting in the u	inderlying cause g	ven in Part I.	23e. Did toba	icco use contribute	to the cause of death?
- sp	w requires that the death cer been signed by the attendir should be detached for use		A/colio	Abuse				1 ☐ Yes	2 □ No 3 □ F	robably 4 Unknown
ar field	aw rec s bee 2 shou	Completed	FATTY	SUER				24a. Was an	24b. Were a	utopsy findings available
Sarfie of Vital Rec	ysician: The law is certificate has b director, page 2 sl	mo						autopsy performe	ed?   death?	completion of cause of s 2 No
Z _	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?					n (Check only one,		
C 17 5		2	1 ☐ Yes 2 No	1 Ainpatient 21	ER/Outpatie	nt 3 DOA	ther: 4 🗆 Nursing Ho			ecify)
id (	ding F h. After funer	tion	1 Natural 5 ☐ Pending	Ba. Date of Injury (Month, Day Year)	28b. Time o Injury	Wo	ork? ☐Yes 2☐No	28d. Describe how	injury occurred	
loyd	for Attending after death.  Diractor: After in by the fune	ifica	a Could got be	Be. Place of Injury - At building, etc. (Spec	home, farm, st	40.00		28f. Location (Stre	et and Number or F	Rural Route Number,
100	tal or Arsafter al Dira	Certification;	4 Homicide	building, etc. (Spec	city)			City or Town,	State)	
77	To the Hospital or Attending Ph within 24 hours after death, To the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier (Check only one) Certifying Physicie 2 Medical Examiner:	n: To the best of my ki On the basis of examinand manner stated.	nowledge, deal nation and/or in	th occurred at the to extra the transfer of th	time, date and place, opinion, death occur	and due to the cau red at the time, dat	ise(s) and manner a e and place, and du	is stated. e to the cause(s)
	o the	Med	29b. Signature and title of certifier	and marmer stated.		29c. Licen	ise number	290	d. Date signed (Mor	oth, Day, Year)
	P > P 0		Kousino /ma	ms om	0	Do	001546	6	11-21-	05
			30. Name and address of poson who compl	eted cause of death (Ite	em 23a) (Type	Print)		_	,,	05 EDACE 2/02
			RAMIRO R LIND	ADO - H	·M·H	501	5. UNION	X AUC-	HOURE DE	EDACE 2102
1	Sta Regist	ate ' rar	31. Date fred (Month, Day, rear)	32. Hegistrar's Sigi	nature					
DI		24	MOV 0 9 2005	Bear 1	Goo	w				
			•		ORIGIN					

		•	1 - For Stata Registrar	State of Marylar		artment of F			giene 2005	37687
			Decedent's Name (First, Middle, L.	ast)				2. Date of Dea Month		3. Time of Death
	Physici /Medic	_	Donald Forrest					Novembe	r 3, 2005	6:03 P M
1	Examir	er	4a. Facility Name (If not institution, gr			4b. City, Town, o	_	ath	4c. County of Dea	
	Funeral		Suburban Hospita 5. Social Security Number 6.	a1 Sex 7. Age (In yrs.	last birthday)	Bethese If Under 1 Year	If Under 24 Hr	s. 8. Date of Birth	Montgome 9. Bi	thplace (State or Foreign
	Funeral Director		349-14-5741	150 M 2□ F 78	Yrs.	Months Days	Hours Mir	June 24		inois
	pur *		Usual Residence of Decedent  10a. State 10b. County	10c. Ci	ity, Town or Lo	ocation				10d. Inside City Limits
	Maryli f sho	ō				View				1 □Yes 2 ½ No
	r 28a	rec	Delaware Susse	5X	ocean	10f. Zip Code			10g. Citizen of What C	ountry?
	23a c	Funeral Director	E143 Cedar Shore	es		199	970		USA	
	er dez	nue	11. Marital Status	12. Was Decedent Ever in L Armed Forces?	J.S. 13.	Was Decedent of H If Yes, specify Cubi	lispanic Origin? ( an, Mexican, Pue	Specify Yes or No- into Rican, etc.)	14. Race - Am Black, Wh	
39	n 72 hours after death with the Maryland "naturel", or iteme 23a or 28a-f show salical Examinar must be notified at	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	1 XYes 2 □ No If Yes, Give Year or Dates:1945 -	-46	1 ☐ Yes 2 🙀 No	Specify:		Specify:	ite
21215-0036	72 hou		15. Decedent's l	Education	16a. Dece	dent's Usual Occup		orkina	16b. Kind of Business	
21	d within jiene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	d)		Food & Dru	O
7			17. Father's Name (First, Middle, Las	4	Budg	et Office		ame (First, Middle,	Administ Maiden Sumame)	ration
lan	9 7 5	To Be	Forrest Brown				Agnes	Scan1	on	
Maryland	2 should be and Mental I is marked o	۲	19a. Informant's Name/Relationship		19b. Maili	ng Address (Street			r, City or Town, State,	Zip Code)
	as 1 and 2 should b of Health and Ment item 27 is marked r other traumatic e		Timothy M. Brown			Dowden	Circle		lle Maryla	
altimore,	t of H to the		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3		Place of Dispo cemetery, cre ce of H	osition (Name of matory or other plants	ce)	Date	20c. Location - City o	Town, State
Ē	permit. Pages in Department of Important: If ite eny injury or ot once.		4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice	iny)	C	emetery 2. Name and Addre		7,2005	ilver Spri	ng,Maryland
Ba	Depar Depar Impor eny tr		Ph. FE	Kamice	Fr	ancis J.	Collins	Funeral	Home, Inc.	MD 20001
		П	23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused the dea						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Pneumoria						Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conse	quence of):					
ı	_,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	-	Sequentially list conditions if any, leading to immediate cause. Enter Underlying	b. Chronic Obst	ructiv	e Pulmon	ary Dise	ase		
	uted d ansit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	c Respiratory	Failur	·e				
oʻ	death certificate be executed e ettending physician and nd for use as the burial-transit		resulting in death) Last	Due to (or as a conse						
8760,	physicist the bu	dlcal		d						
9 x	leath certifica ettending ph I for use as ti	Physician/Medl	IF FEMALE:	23c. If yes, outcome of pregn	ancy				23d. Date of de	livery
Box	death e etter d for u	Iclar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of		□Ectopic pregnanc □ Other (specify) _	y 		Month	Day Year
P.0	et the de by the steched	hys	9 🗆 Unknown	9□ Unknown						
Vital Records, I	law requires thet the es been signed by th 2 should be deteche	þ	Part II. Other significant conditions	contributing to death but not re	sulting in the t	ınderlying cause gı	ven in Part I.		ebacco use contribute f les 2 □ No 3 □ F	o the cause of death?
900	law requir ss been si 2 should	Completed						24a. Was autop		utopsy findings available completion of cause of
Ĕ	The ete h page	Com						pertor	med?   death?	s 2□No
Vita	Physicien: T this certificat ral director, pa	Be	25. Was case referred to medical examiner?	Hospital:			205	eath (Check only o		
of	Phy this	To	1 ☐ Yes 2 🔀 No 27. Manner of Death	28a. Date of Injury	ER/Outpatie 28b. Time o	III JUDOA	4   Nursing		ence 6 Other (Sp.	ecify)
ion	Attending Ir death.	atlor	1 XNatural 5 ☐ Pending 2 ☐ Accident investigat	(Month, Day Year) on	Injury		rk? ]Yes 2∐No			
Division	or Atta after des Directo in by th	Certification:	3 Suicide 6 Could not 4 Homicide determine	28e. Place of Injury - At the building, etc. (Special Control of the building)		reet, factory, office		28f. Location (S City or Tow	itreet and Number or F m, State)	lural Route Number,
	ne Hospital or Attandi n 24 hours after death he Funeral Director; A pletely filled in by the fu	edical Ce		Physician: To the best of my kn aminer: On the basis of examin						
	To the Hos within 24 h To the Fun completely	Medi	29b. Signature and life of certifier	and manner stated.		29c. Licens			29d. Date şigned (Mor	
	F % F 8		I found to	n MD			57/82	+	1 . 1	DOS
11	)+1		30. Name and address of person wh	o completed cause of death (Ite	m 23a) (Type	. Print)		·	-11/1-	
10			Caitriona Buck			eorgetown	n Koad,	betnesda,	MD 20814	
	St: Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature	cells				

DHMH 17 Rev 1/2001

11/3/05

Brown Donald

			1 - For State Registrar	State of Ma	aryland / Depa <i>Cei</i>	artment of H			giene Reg. No. 0	05 37	688
	Physici	an	Decedent's Name (First, Middle, L	_	D			2. Date of Dea Month	ath Day	1/	of Death
	/Media	ai	James 4a. Facility Name (If not institution, g	A.	Bryant	4b. City, Town, or	Leasting of Dog	Oct.	8, 2005		Ам
	Examir	ier	Anne Arundel Med		-	Annapoli		ın	4c. County	Arundel	
	Funeral		Social Security Number 6.	Sex 7. Ag	e (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs		h	9. Birthplace (Stat Country)	e or Foreign
	Director		218–76–1508	¹₹M 2□F 44	Yrs.	Months Days	Hours Min.	May 4		Maryland	
	and *		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside	City Limits
	Mary!	ō	MD Queen	Annes	Stevensv						es 2 ⊋ No
	r 288	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of V		21
	th with		133 Penny Lane			21666			USA		
	r dea	Funerai	11. Marital Status	12. Was Decedent   Armed Forces?		Was Decedent of Hi f Yes, specify Cubar	spanic Origin? (9	Specify Yes or No- rto Rican, etc.)		e - American Indian, ck, White, etc.	
36	s afte	by Fu	1X Never Married 2 Married 3 Widowed 4 Divorced	If Yes, GiveXX	No .	1 ☐ Yes XXNo	Specify:			White	
Ş	within 72 hours after death with the Maryland ene. than "naturel", or iteme 23e or 28e-f ahow he Modical Examinar Luari be motified at	edt	15. Decedent's	Year or Dates:	16a, Deced	dent's Usual Occupa	ation			usiness/Industry	
215	hin 7.	Completed	(Specify only highest g Elementary/Secondary (0-12)	grade completed) College (1-4or 5	life. I	kind of work done d DO NOT use retired,	uring most of wo	nrking		,	
2	or the	Corr		2	CAD				Enginee	ring	
n D	be file d oth	Be	17. Father's Name (First, Middle, Las					me (First, Middle,	Maiden Sumam	re)	
Maryland 21215-0036	d Men narke	2	David A. Bryant  19a. Informant's Name/Relationship		405 14-17-			ia Dobbs			
Z Z	id 2 si Ith an 17 le r traur		Pat Church (Moth			Ganna Desi				State, Zip Code)	
ē,	f Heal		20a. Method of Disposition	<u>er)</u>	20b. Place of Dispo	Sonne Dri		Date Date		City or Town, State	
Ë	Page nent o nt: If ry or		1 ☐ Burial 2 X Cremation 3 4 ☐ Donation 5 ☐ Other (Spec			natory of other place ematory		12-2005	Baltimo	ore. M-	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 ie marked other than "naturel", or iteme 23a or 28a-f ahow apprintury or other traumatic event, the Medical Examiner mant be notified at anone.		21. Signature of Funeral Service Lic	ensee	22	. Name and Addres	s of Facility				
<u> </u>	89 E 8 9		23a, Part 1. Enter the disease, or co	rem	<u> </u>	lardesty E	uneral Vavenue	Home, P.	A. lie MD	21.401	
j.	Physician /Medical Examiner	Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. Due to (or as	0.	viis				Interval E Onset an	
. Box 68760,	The law requires that the death certificate be executed ate hes been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	d. 23c. If yes, outcome 1 Live birth 4 Pregnant at	2 Fetal death 3	Ectopic pregnancy		=====	23d. Dat	e of delivery nth Day	Year
Ö.	thet the de led by the a detached	hys	9 □Unknown	9□ Unknown							
rds, l	w requires the been signed should be de	þ	Part II. Other significant conditions	contributing to death bu	ut not resulting in the ur	nderlying cause give	n in Part I.	23e. Did to	. /	abute to the cause of 3 ☐ Probably 4 [	
Division of Vital Records, P.O.		Completed						24a. Was a autop: perfor	med? p	Vere autopsy finding prior to completion of leath?	s available cause of
<u>₹</u>	Attending Physicien: The of death. rector: After this certificate by the funeral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Othe		ath (Check only or			
ō	Phys rthis raldi	. To	1  Yes 2 No 27. Manner of Death	1 fnpatie			4 Li Nuising r	dome 5 ☐ Resid			
on	nding ath. r: Afte e funé	atior	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigati	(Month, Day	Year) Injury	28c. Injury Work 1 □ Y	es 2 No	-		BUTWITHER	RETREE
Vis	or Attendent efter deatl Director: Jin by the	Certification:	3 ☐ Suicide 6 ☐ Could not determine		ury - At home, farm, stre			-	treet and Numbe	er or Rural Route Nu	
	Ital or A	Cer			Daway					UTRI) QUEEK	
	To the Hospital or Attending Physician: within 24 hours effer death. To the Funerel Director: After this certificy completely filled in by the funeral director.	ical	(Check only 2 Medical Ext	Physician: To the best of aminer: On the basis of	examination and/or inv	occurred at the time restigation, in my op	e, date and place inion, death occi	e. and due to the o	ause(s) and ma	nner as stated	
	thin 2 the implet	Medical	one)  29b. Signature and title of certifier	and manner sta	ated.	29c. License				(Month, Day, Year)	
	F 3 F 8		DIV 0	malk- on	YW		ME		OCT 8,		
			30. Name and address of person who	o completed cause of d	eath (Item 23a) (Type. I		, , ,				
_			MARGAMIN	D. KUREL		unit ba	unmoni	5 MD =	21201		
61	Sta Registr	-	31. Date filed (Month, Day, Year)  OCT 1 4 20	Registra	ar's Signature	rolly					

Amend Item 26,11/7/05State of Maryland / Department of Health and Mental Hygiene Cecil Co., ddt ... State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Eleanor D. Borland November 4, 2005 2:25 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 695 Colora Road Colora Cecil If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Days 1 M 2 X F Yrs. Director 168-12-2548 86 May 21, 1919 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10d. toside City Limits 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28e-f show other treumstic event, the Modical Examiner market by notified at 1 ☐ Yes 2 No Director Maryland Cecil Colora 10e. Street and Number 10f. Zip Code 10g. Cifizen of What Country? 695 Colora Road 21917 **USA** Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, Whife, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 ☑ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Physician Medical and Mental Hygie Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Anthony Triboletti Margaret Granese 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Raymond Borland/Son 695 Colora Road, Colora, MD 21917 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State o 1 Burial 2 ☐ Cremation 3 ☐ Removal from State = permit. Page Department of Importent: If any injury or once. West Nottingham Cem. 11-7-2005 \* 4 ☐ Donation 5 ☐ Other (Specify) Colora, Maryland R. T. Foard Funeral Home, P.A 111 S. Queen St., Rising Sun, 21. Six mure of uneral Service Licens P.A. whang MD 21911 23a. Part. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one gauge on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease r condition resulting in death) ges CUR Physician /Medical Due to (or as a cons to ce of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine certificate be executed as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): physician 68760 Physician/Medical Box IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐ Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, à 2 No cate has been sig 3 ☐ Probably 4 ☐ Unknown 1 Tes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 No autopsy Vital 1 ☐ Yes director 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: 1 ☐ Inpatient Other: 1 🗌 Yes 3□ DOA 4 ☐ Nursing Home 5 💢 Residence 6 ☐ Ofher (Specify) tpatient of this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: Injury vatural 5 Pending 2 Acoident death. 1 ☐ Yes 2 ☐ No investigation or Attendation of after death 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Sertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. within 2 the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) and 0 death (Item 23a) (Type, Print) 30. Name and address of person who completed cause 2 2 Norms 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State 0 7 2005 Registrar

			4 177	artment of Health and Ment rtificate of Death	tal Hygie	ZUUD	37690
	Physici		1. Decedent's Name (First, Middle, Last) Donald · BANTNER	l M	ate of Death Nonth	Day Year 2 2005	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	1
			Pleasant View Nursing Home	Mt. Airy		Howard	
П	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Yrs. 73	Months Days Hours Min. (N	ate of Birth Month, Day, Ye Ly 24 ,	9. Birth Con 1932 II	place (State or Foreign Intry) Linois
	pu ,		Usual Residence of Decedent			2000 12	
	anyla shov	J.C					10d. Inside City Limits 1 ☐ Yes 2 ☑ ▼o
	the M	Director	Maryland Howard Mt. Ai	TY 10f. Zip Code	100	. Citizen of What Cou	
	h with	i Di	4101 Old National Pike	21771		USA	
	ams 2	Funerai		Was Decedent of Hispanic Origin? (Specify Y If Yes, specify Cuban, Mexican, Puerto Rican,	res or No-	14. Race - Amer	
36	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artenent of Haalth and Mental Hygiene. ortant: if Itam 27 is marked other than "natural", or Itams 23a or 28a-f show injury or other traumatic avant, the Modral Examiner must be notified at injury or other traumatic avant, the Modral Examiner must be notified at 9.	by Fu	1 ☐ Never Married 2000 Married 500 Yes 2 ☐ No 1952	1 ☐ Yes 🏖 TNo Specify:	, 610.)	Black, White Specify:	
21215-0036	2 hour		1733	dent's Usual Occupation	168	b. Kind of Business/li	White
215	within 72 ene. than "nu	pie	(Specify only highest grade completed) (Give	kind of work done during most of working DO NOT use retired)			,
21	e filed within at Hygiene. I othar than 'vant, the Mo	Completed	12 2 Manag			nited Iron	& Metal
Maryland	ntai H ed oth	Be	17. Father's Name (First, Middle, Last)  Charles Leo Bantner	18. Mother's Name (First		den Sumame)	
I V	2 should be and Mental is marked c	L L		ng Address (Street and Number or Rural Rout		itv or Town. State. Zi	n Codel
	and 2: lealth ar m 27 is har trau			e Hill Dr. Westmins			<i>p</i> 00 <b>1</b> 0,
ore,	of Ha of Ham I Itam r othe		20a. Method of Disposition 20b. Place of Dispo			c. Location - City or T	own, State
Ĕ	Pagment ment: il ant: il		`4 □Donation 5 □Other (Specify) Carroll C	remation Inc 11/4/20		ampstead,	
Baltimore,	permit. Pages 1 an Department of Haali Important: if Itam 2 any injury or other once.		21. Signature of Funeral Service Licensee	<sup>2. Name and Address of Facility</sup> Pritts Funeral Ho 2 Washington Rd. West	ome and	d Chapel,	P.A. 157
			23a. Part 1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.				Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition a. BRONCHE Prosulting in death)	MEUMONIA			Onset and Death
	/Medical Examiner		Due to (or as a consequence of):	000-0 000			40
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Disease or injury  HUDERTBM	ARTERY Disease			Jean
	cuted id ransit	Examiner	that initiated events	SIEN			Jeans.
,0	cate be executed physician and the burial-transit		resulting in death) Last Due to (or as a consequence ol):				
8760,	physic physic the b	dica	d				
9 xc	# O G	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of deliv	95/
. Box	that the death cer ed by the attendir detached for use	Physician/Medical	in the past 12 months? 1 □ Live Dirth 2 □ Fetal death 3 □ Live Dirth 2 □ Fetal death 5 □	Ectopic pregnancy Other (specify)		Month	Day Year
P.0.	at the 1 by th stache	Phys	9 Unknown				
Vital Records,	es Dan	by	Part II. Other significent conditions contributing to death but not resulting in the u  Alzheimers Dementia	inderlying cause given in Part I. 2.	3e. Did tobac 1 ☐ Yes	co use contribute to to 2 No 3 Pro	the cause of death?  bably 4 Unknown
CO	aw requir is been si 2 should	Completed		24	4a. Was an	24b. Were aut	opsy findings available
E E	Physician: The law r this certificate has t ral director, page 2 s	Com		11	autopsy performed ☐ Yes 2 2	death?	mpletion of cause of
/ita	cian: ertific ector,	Be	25. Was case referred to medical examiner?	26. Place of Death (Che-			
of	Physician: this certificatal director, I	- To	1				fy)
OU	ding h. After funer	tion	1 Natural 5 Pending (Month, Day Year) Injury 2 Accident investigation	f 28c. Injury at Work?  M 1 ☐ Yes 2 ☐ No	escribe now i	njury occurred	
Division of	Atten r deal actor: by the	Certification:	3 Suicide 6 Could not be	reet, lactory, office 28f. Lo		t and Number or Run	al Route Number,
Ö	ital or rs afte al Dir	Cert			ity or Town, S	·	
	To tha Hospital or Attanding Ph within 24 hours after death. To tha Funaral Diractor: After th completely filled in by the funeral	edical	29a. Certifier (Check only one)  1 ★ Cartifying Physician: To the best of my knowledge, deatled the basis of examination and/or in and manner stated.	h occurred at the time, date and place, and du vestigation, in my opinion, death occurred at the	ue to the cause the time, date	e(s) and manner as s and place, and due t	stated. to the cause(s)
)		IA.	29b. Signature and title of certifier  AB Collection	29c. License number D · 30 4-69	No	Date signed (Month,	Day, Year)
	WILL	1,	30. Name and address of person who completed cause of death (Item 23a) (Type, 8850, COLU IB; A 100 VARKW HY	Print) N.B. VELLANKI	AM.D.	Mg , 211	45
	Sta		31. Date liled (Month, Day, Year) 32. Registar's Signature				
	Registr	ar	NOV 0 4 2005 Shows &	Spell			

KHENT T. CHAPMAN 05-07491 RKD

			State of Maryland / State Unpend Item 23a,27,28a-f per Registrar	me G850 12-2-05 tas	Reg	ne n2005	37691
			Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	Physicia /Medic		Khent Teague Chapman		NOVEMBER	6, 2005	4:20P. M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
			7990 GEORGIA AVE	SILVER SPRING		MONTGOMER'	Y
	Funeral Director		5. Social Security Number  380-06-9063  Usual Residence of Decedent  6. Sex 120 M 2□ F  7. Age (In yrs. last to 22)	birthday) Yrs.  If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Ye Mar. 31,	9. Birthple Count 1983 Micl	ace (State or Foreign ry) nigan
	and	ł		own or Location		10	d. Inside City Limits
	Mary	ō	Maryland Montgomery Silve	r Spring			1X Yes 2 No
	28a	ec	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Count	ry?
	3a o	Funeral Director	8811 Colesville Road #802	20910	III	nited State	28
	deati	ner	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto		14. Race - America	ın Indian,
9	or its	F	1 Never Married 2 Married 1 Yes, 2 No If Yes, Give	1 ☐ Yes 2 No Specify:	o Rican, etc.)	Black, White, e	
8	hours after death with the Maryland tural; or Items 23s or 28s-f show al Examinat russ be motified at	d by	3 Widowed 4 Divorced Year or Dates:	TET 185 2X NO Specify.		Specify: African A	American
5	72 h	Completed	15. Decedent's Education (Specify only highest grade completed)	Sa. Decedent's Usual Occupation (Give kind of work done during most of work	king 16b	b. Kind of Business/Ind	ustry
121	within 72 ene. then nai	mp	Elementary/Secondary (0·12) College (1-4or 5+)	life. DO NOT use retired)		0	
22	be filed within 72 hours after death with the Marylar ital Hygiene. Id other then "natural", or items 23s or 28s-f ehow other, it a Medical Exeminer must be notified at event, it a Medical Exeminer must be notified at		17. Father's Name (First, Middle, Last)	FEMA Telephone Suppo	ne (First, Middle, Maid	Government	
Maryland 21215-0036	Mental harked of	Be	Raymond Leon Chapman		atricia Jo		
Ë	2 should be and Mental is marked (saumatic ev	2		9b. Mailing Address (Street and Number or Ru			Code
<u>≅</u>	permit. Pages 1 and 2 should by Department of Health and Menta important: if item 27 is marked any injury or other traumatic e- once.			8811 Colesville Rd. #			
ē,	Heal Form		20a. Method of Disposition 20b. Place	of Disposition (Name of		c. Location - City or Tov	
<u></u>	ages int of t: if if		1 🗆 Burial 2X Cremation 3 🗆 Hemoval from State	tery, crematory or other place) apeake Crematory 11/1		ŕ	
Baltimore,	artme ortan injur	i i	21. Signature of Funeral S, rvice Licensee	22. Name and Address of Facility Mc		eltsville,	
Ba	Dermi Impo any i		andre Thompson	7400 Georgia Ave.			
			23a. Part1. Enter the disease, or complications that caused the death. D				Approximate
	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final		mahan Chi		Interval Between Onset and Death
Jan.	/Medical		disease or condition resulting in death)  A a. Mixed Drug Int  Due to (or as a consequence)	coxication(Dextrometho	or phan, Chit	or buentram	ine)
	Examiner						
		ner	Saquentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	ee of):			
	cutec nd ransl	Examiner	that initiated events C.				
Ö,	e be executed /sicien and e burial-transit		resulting in death) Last Due to (or as a consequence	ee of);			
8760	w 2 0	Ilcai	d				
x 68	The law requires that the death certificate the been signed by the attending phy age 2 should be detached for use as the	Physician/Med	IF FEMALE:		-	1	
Вох	ath countriend	lan/	23b. Was decedent pregnant in the past 12 months?			23d. Date of deliver Month	y Day Year
0	at the de by the a stached f	ysic	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown	5 Other (specify)			,
<u>α</u>	that the	F.	Part II. Other significant conditions contributing to death but not resulting	g in the underlying cause given in Part I.	23e, Did tobaco	co use contribute to the	a cause of death?
Vital Records,	sign d be	d by		,	1 ☐ Yes		
Ö	w requir been si should	Completed					
ž	has has	mp			24a. Was an autopsy performed	prior to corr	sy findings available inpletion of cause of
a					1 Yes 2□		2□ No
₹		o Be	25. Was case referred to medical examiner?  Hospital: Hospital:		th Check only one	-37	CCENE
	Phys this ral di		1   Inpatient 2   EHV	Colpation 30 DOX 40 Norsing H		e 6 Nother (Specify,	POEME
of			1 Natural 5 Pending Found Cay Year) Fo	Ound: Work?		unk	
	ding th. Alter	tlor	Z Nocident	:00 P <sup>M</sup>   100 2 X 100		t and Number or Rural	- 1
	Attending r death.	fication	6 Could not be	farm, street, factory, office	28f. Location (Stree		Route Number,
Division of	al or Attending after death. I Director: Alter d in by the fune	ertification	3 ☐ Suicide 4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  5 ☐ Could not be determined building, etc. (Specify)	farm, street, factory, office	28f. Location (Stree City or Town, S Silver Sn	ring Mary	Route Number, rgia Avenue land
	sspital or Attending hours after death. inerai Director: Altei y filled in by the fune	ai Certification:	3 Suicide 4 Homicide  6 A Could not be determined  28e. Place of Injury - At home, building, etc. (Specify)  Hotel/Motel  29a. Certifier  1 Certifying Physician: To the best of my knowled	dge, death occurred at the time, date and place	and due to the cause	ring, Mary.  e(s) and manner as sta	Land uted.
	he Hospital or Attending n 24 hours after death. he Funeral Director: Atter pletely filled in by the fune.	edical	3 ☐ Suicide 4 ☐ Homicide  5 ☐ Could not be determined  5 ☐ Could not be determined  5 ☐ Homicide  4	dge, death occurred at the time, date and place	and due to the cause	ring, Mary.  e(s) and manner as sta	Land uted.
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: Atter completely filled in by the funer		3 Suicide 4 Homicide  6 A Could not be determined  28e. Place of Injury - At home, building, etc. (Specify)  Hotel/Motel  29a. Certifier (Check only)  2 Medical Examiner: On the basis of examination	dge, death occurred at the time, date and place	, and due to the causified at the time, date	ring, Mary.  e(s) and manner as sta	ated. the cause(s)
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	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Alter completely filled in by the fune	Medical	3 Suicide 4 Homicide  28e. Place of Injury - At home, building, etc. (Specify)  Hotel/Motel  29a. Certifier (Check only one)  2 Medical Examiner: On the basis of examination and manner stated.  29b. Signature and title ef certifier  30. Name and address of person who completed cause of death (Item 23a)	dge, death occurred at the time, date and place and/or investigation, in my opinion, death occurred at the time, date and place and/or investigation, in my opinion, death occurred to the control of the	, and due to the causered at the time, date 29d.	e(s) and manner as ste and place, and due to  Date signed (Month, D  EMBER 7, 200	ated. the cause(s)  Day, Year)

			1 - For Amend Item Registrar	State of M per Dr.	laryjar • • <b>G84</b>	10 / Dep 19,11,72	artment of 2705dhb rtfricate o	Health f Deat	and M		giene Reg. No.	05	37692
	Physici	an	1. Decedent's Name (First, Middle, Last	40 -			_	-		2. Date of De	ath Dav	Yeer	3. Time of Death
	/Medic		ARTHUR KARL			USICI				11	12	05	7:45 PM
	Examin		4a. Facility Name (If not institution, give				4b. City, Town					unty of Death	
			5. Social Security Number 6. Se	EDICAL C		last birthday	BETY-		er 24 Hrs.	8. Date of Birt		UTGON	
	Funeral Director			<b>X</b> M 2□F	63	Yrs.	Months Day			(Month, Da Aug. 13	ÿ, Year) 3,1942	Cou	place (State or Foreign htry) Jersey
	D		Usual Residence of Decedent				I				,,,,,,	1100	
	trylan thow	_	10a. State 10b. County		10c. Ci	ity, Town or L	ocation						10d. Inside City Limits
	Ba-1 s	Director	Virginia Fauquier		War	renton							1 Tyes 2X No
	with th		10e. Street and Number				10f. Zip Code				10g. Citizen	of What Coul	ntry?
	eath v	era	7231 Paddock Way	12. Was Deceden	t Cupe in I	16 12		186	Delaine (Co.	-4. V N-	USA	Dana Amad	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other then "natural; or items 23e or 28a-1 show other treumatic event, the Medical Estimation and the notified at	by Funeral	11. Marital Status  1 □ Never Married 2 ☒ Married  3 □ Widowed 4 □ Divorced	Armed Forces  1 Types 2 If Yes, Give Year or Dates:	?  No 2	2001	Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 ☒ N			Rican, etc.)	1	Race - Americ Black, White, ecify: W	
2-0	72 ho	Completed	15. Decedent's Edu (Specify only highest grad				edent's Usual Occ		ant of worki		16b. Kind	of Business/In	dustry
21	within ene. then "	nple	Elementary/Secondary (0-12)	College (1-4or		life.	DO NOT use reti	red)	OSI OI WOIKI	ng .			
2	e filed w al Hygier other th		17. Father's Name (First, Middle, Last)		5+	Vi	ce Admir			<b></b>		. Navy	
anc	l be fi	Be	John S. Cebrowski							(First, Middle,		name)	
Maryland	should be nd Mental marked matic ev	မ	19a. Informant's Name/Relationship (T	(ne Print)		19h Mail	ng Address (Stre	Hel		Siekier	200	um State 7in	Codel
⊠	nd 2 s lith an 27 is r treu		Kathryn M. Cebrows				1 Paddoc					WII, SIA16, ZIP	(000)
ē,	s 1 and 2 f Health Item 27 i		20a. Method of Disposition	· ·	20b.	Place of Disp	osition (Name of			ate		on - City or To	own, State
E O	Page ent o nt: if ry or		1X Burial 2 ☐ Cremation 3 ☐ I 14 ☐ Donation 5 ☐ Other (Specify)				matory`or other p n Nation		1/9/0	)6	Arlina	aton. N	/irginia
Baltimore,	permit. Pages I Department of H Importent: If ite any injury or ot once.		21. Signature of Funeral Service License	e CH		2	2. Name and Add Moser Fu	ress of Fac neral	Home		roadvi		, Warrento
	100		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	ications that cause	d the dea	th. Do not en	ter the mode of d	ring, such a	as cardiac o				Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	h.	pulm	quence of):	+ Arres	+					Onset and Death
	Examiner	er	if any leading to immediate	Complic			nonia						
	outed ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Hepotic	Abo	15525	auch l	sacter	-emice	and	funci	omia.	
oʻ	en ar		resulting in death) Last	Due to (or as	s a consec	quence of):							
8760,	icate be executed physicien and s the burial-transit	dicai		Metasi	toute	Trans	etion al	(eil	Car	cinom	<u>a</u>		
Box 6	ath certif ttending or use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 🗌 Feta	al death 3	⊒Ectopic pregnan	су			1	Date of delive	ory Day Year
P.O.	0 00	hysic	1 Yes 2 No 9 Unknown	4□Pregnant a 9□ Unknown			Other (specify)						ou, ou
Records,	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions co	ntributing to death	but not res	sulting in the t	inderlying cause o	ven in Par	t i. 	23e. Did to			ne cause of death? ably 4 Unknown
Rec	The ate h page	Completed								24a. Was a autop perfor 1 Yes	sy	b. Were auto prior to cor death? 1 \( \sum Yes	psy findings available inpletion of cause of
/ita	Physicien: T rthis certificat ral director, pa	Be (	25. Was case referred to medical examiner?						ce of Death	(Check only or	ne)		
of \	Physicien: this certific al director,	7	1 ☐ Yes 2 No	lospital: 1 Inpati		ER/Outpatie	IL 3 DOX		-	ne 5□ Resid			/)
Division of Vital	ing After	Certification:	27. Manner of Death  1 Natural 5 Pending  2 Accident investigation  3 Suicide 6 Could not be	28a. Date of Inj (Month, Da	ay Year)	28b. Time o Injury	M 1[	ork? ]Yes 2[		8d. Describe h	ow injury oc	curred	
Divi	2 4	Certifi	4 Homicide determined	building, e	tc. (Specii	fy) 	reet, factory, office			City or Tow	n, State)		l Route Number,
	To the Hospitel of within 24 hours at To the Funeral D completely filled in	Medical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best ner: On the basis of and manner s	ot examina	owledge, deat ation and/or in	h occurred at the vestigation, in my	ime, date a opinion, de	and place, a eath occurre	nd due to the d ad at the time, d	ause(s) and date and plac	l manner as st ce, and due to	ated. the cause(s)
	To To Com	2	29b. Signature and title of certifier	N (1)				ise numbei				gned (Month,	Day, Year)
ŧ			> Vinsma	_ B.U.			01	022	014	18	11/15	105	
	12		30. Name and address of person who co				325	H Q. 9 Cas		ve, a	iantii	OVAZ	2134-6050
	Sta Registr	_	31. Date filed (Month, Day, Year)  NOV 2 2 2005	32. Regist	rars Signa	ature	U.						

State of Maryland / Department of Health and Mental Hygienen 05 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November 4, **Physician** 2005 FRANCES JANE CARMACK 5:45 Рм /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Frederick Northampton Manor Nursing Home | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Nov. | 18, 1924 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🔽 F Maryland 220-18-1384 80 Director Usual Residence of Decedent the Maryland 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits other treumatic event, the Medical Examiner must be notified at 1 Yes 2 No Directo Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21702 1421 Taney Avenue U.S.A. 23a by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 2 should be filed within 72 hours after a and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 → No Specify: Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Assembler Frederick Electronics 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Clarence Myers Sarah Pittinger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an ent: If item 27 is Deborah S. Calpin (Daughter) 7779 Trappers Road, Fayetteville, NC 28311 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or once. Smithsburg Crematory 11/8/2005 Smithsburg, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses ROBERT É. DATLEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701 23a. Part1. Enter the disease. Approximate Interval Between Onset and Death not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure Immediate Cause (Final disease or condition resulting in death) NEGATI VE Physician /Medical Due to (or as a consequence of) Examiner OBSTRUCTION NEEKI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit BI LI ARY CARGINOMA mos Due to (or as a consequence of): attending physician for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Year Day 4☐Pregnant at time of death 5 Other (specify) \_ 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CONGESTIVE HEART CANCER OFBREAST 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown CANLER OF COLON 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA | Other: 4 | Nursing Home 5 | Residence 6 | Other (Specify) 1 ☐ Yes 2 € No 2 nours after death.

nerel Director: After this filled in by the funeral di 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 TYes 2 No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide 24 hours 29a. Certifier 1 👺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D-31912 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Julio MENOCIM, ND - 1514 opossumann pins, FREDERICH Registrar's Signat **3°8** 2005

DHMH 17 Rev 1/2001

Registrar

Justin Carlson 05-07665 MUN

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

665		For State			•		of He	ealth a		lental Hy	- 6	005		37694	
Physicia	n	1. Decedent's Name (First, Middle, Las.				tinoato	0, 2	<i></i>		2. Date of De Month Novembe	Day	3 2ď	<u></u>	3. Time of Death	-
/Medica Examine		4a. Facility Name (If not institution, give	_		rison	4b. City, To				140 V CIND		County of		0149	
Funeral Director		University Hospi 5. Social Security Number 6. Sec 222-76-0807	x 7	. Age (In yrs. 17	last birthday) Yrs.	If Under 1		nore If Under 2 Hours	24 Hrs. Min.	8. Date of Bir (Month, Da SEPT 2	th y, Year) , 198	88	Birthp Coun Dela	lace (State or Foreigi try) IWare	7
Maryland f • how	lor	Usual Residence of Decedent  10a. State 10b. County  Maryland Cecil			ty, Town or Lo	cation							1	0d. Inside City Limits	
or 28a-	Directo	10e. Street and Number		1 14.	IKCOII	10f. Zip C						zen of Wh		•	
or items 23s	Funeral	13 Arundel Lane 11. Marital Status 1	12. Was Deced Armed Ford 1 Tyes 2 If Yes, Give	es? [X] No				spanic Origin, Mexican	gin? (Spe i, Puerto	ecify Yes or No Rican, etc.)	)- 1	nited  14. Race - Black,  Specify:		an Indian,	
nin 72 hours n "naturel",	Completed by	3 Widowed 4 Divorced  15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	Year or Dat	es:	16a. Dece	dent's Usual kind of work DO NOT use	Occupa done di	tion uring most	t of worki	ng		nd of Busi	Whi ness/Ind		
iled with tygiene ther the		12  17. Father's Name (First, Middle, Last)	College (1-4	+01 5+)	Stı	ıdent		18 Mothe	ar's Name	(First, Middle		igh S		01	_
uld be fi Aental H rked ot tic ever	To Be	Phillip B. Carl	son							Stackle		Jumame			
d 2 sho th and h 7 is ma treuma	•	19a. Informant's Name/Relationship (7  JoAnn Rankin/Mo				-				ton, Ma					
ages 1 an out of Heat		20a. Method of Disposition  1 Ma Burial 2 Cremation 3 4 Donation 5 Other (Specify	Removal from S	ate Gr	Place of Dispo cemetery, crea acelawi rk	eition (Name	a of		Nove	mber	20c. Loc	cation - Ci	ity or To		
permit. P Departme importan eny injur.		21. Signature of Funeral Service Licans		hs)	H-22 H-10	Name and icks H	Address ome Stoc	s of Facility for kton						nd 21921	_
Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	olications that call one cause on ear	used the dear										Approximate Interval Between Onset and Death	
/Medical Examiner	_		b	r as a consec	3		(	7							_
te be executed ysicien and le burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	r as a consec	,										
Physician: The law requires that the death certificat this certificele has been signed by the attending phyral director, page 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		th 2 ☐ Feta nt at time of d	al death 3[	Ectopic pred Other (spec					2	3d. Date Month		ory Day Year	
law requires that es been signed be ceta	۾	Part II. Other significant conditions of	ontributing to dea	ith but not res	sulting in the u	nderlying cau	use give	n in Part I.		23e. Did t		-		ne cause of death?	1
The lawre cete hes be	Completed									24a. Was auto perfo 1 Tyes		pride	or to cor ath?	psy findings available protein of cause of 2 No	)
VICAL VSician: 1 S certifice director, p	o Be	25. Was case referred to medical examiner? 1 □ Yes 2 □ No	Hospital: 1 □ In	patient 212	ER/Outpatier	nt 3 DOA	Othe			n (Check only only only only only only only only		G □Other	(Specifi	()	_
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certification: T	27. Manner of Death  1 Natural 5 Pending investigation  3 Suicide 4 Homicide 6 Could not be determined	28a. Date of (Month) 11 - 12 28e. Place of	Injury Day Year)	28b. Time o Injury ZZ: 4 come, farm, st	5 M			No	DYIVIVE ONEN C	how injury  Let (  Street and wn, State)	isoch	eje or Alira	COCIACOL CX YOULC CX YOULC I Route Numbers 6	2
Hospit 24 hour Funer stely fills	Medical	29a. Certifier 1 Certifying Ph (Check only one)	ysicien: To the base and manner	sis of examina	owledge, deat ation and/or in	h occurred at vestigation, i	t the tim in my op	e, date an pinion, dea	id place, a	and due to the ed at the time,	cause(s) date and	and manr place, an	ner as st d due to	ated. the cause(s)	
To the within To the compli	Me	29b. Signature and title of certifier	Au	1	M		License	number						Day, Year)	
2		30. Name and address of person who	exim X	W.		111	Per	nn St	reet	Balti				nd 21201	
Sta Registra	- I	31. Date filed (Month, Day, Year) NOV 2 1 2005	32. Re	gistrar's Sign	ature	r e									
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DHMH 17 Rev 1/2001

# ARLIED LACKESE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** OCTOBER 37, 2005 ARLEEN THERESE CURRAN 8:26 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner WESTMINSTER CARROLL CARROLL HOSPITAL CENTER If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth MARCH 20,1916 5 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 216-03-1412 1 □ M 3 X 89 MARYLAND Director Usual Residence of Decedent 10a State 10h. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f ebov other traumatic evant, the Medical Examinar must be neithfor at 1 □ Yes 2 No Director MARYLAND CARROLL HAMPSTEAD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2800 HAMPSTEAD-MEXICO ROAD 21074 UNITED STATES Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XX No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: XXWidowed 4 ☐ Divorced WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) 1 and 2 should be filed within Health and Mental Hygiene. Elementary/Secondary (0-12) 12 College (1-4or 5+) HOMEMAKER DOMESTIC 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CHARLES M. KREINER. SR. BERTIE DORER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S. JENNIFER HOWARD/GRANDDAUGHTER 2800 HAMPSTEAD-MEXICO ROAD, HAMPSTEAD, MD 21074 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Oremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) SOUTH CARROLL CREMATORY 11/01/2005 WINFIELD, MARYLAND 21. Signature of Funeral Service Licensee 22 Name and Address of Facility MYERS-DURBORAW FUNERAL HOME, P.A. 91 WILLIS STREET, WESTMINSTER, MD 21157 cenus 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CONGESTIVE HEART FAILURE disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner RILLATION TRIAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit The law requires that the death certificate be executed AIKOMUZUI Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 physician Physiclan/Medical as the t attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Hinknown DEMENTIA Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has 2 No 1 Yes Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Tes funeral dir 1 Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Manner of Death Date of Injury (Month, Day Year) Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation after death. 1 Tyes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 Homicide 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical and manner stated. To the within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0059225

Registrar

5+5

State

Nibha Kohli 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

A sparle

Westminster, MD 2115

bohli

686 C Poole Rd.

32. Regigrar's Signature

NIPHS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NOV 0 2 2005

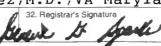
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niner	4a. Facility Name (If not institution,		E SYSTEM		or Location of POINT	Death		onty of Death	
al	VA MARYLAND HI 5. Social Security Number 6	Sex 7. Aq	e (In yrs. last birthday	) If Under 1 Yea	ar If Under 2	4 Hrs. 8. Date of Bi			lace (State or Foreign
or	218-40-2573	1 <b>⊠</b> M 2□F	64 Yrs.	Months Day	/s Hours	4 Hrs. 8. Date of Bi Min. (Month, D NOV 20	, 1940		land
	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation				1	0d. Inside City Limits
ţō	Maryland Ha	rford		Abe	erdeen				1XYes 2□No
i Director	10e. Street and Number 391 South	Drive	I	10f. Zip Code	21001		10g. Citizen	of What Coun	itry?
Funerai	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13	. Was Decedent o	of Hispanic Origi	in? (Specify Yes or N Puerto Rican, etc.)		Race - Americ	
Ē	1 Never Married 2 Marrie	d 1 TXYes 2 □ 1	No ST	1 ☐ Yes 2 🛣 N		Tuesto Filoan, etc.)		_	ack
ed by	3 Widowed 4 Divorced	Year or Dates:	1959-67	edent's Usual Occ	cupation		16h Kind o	of Business/Inc	fustry
Completed	(Specify only highest		(Giv	e kind of work do DO NOT use ret	ne during most ( rired)				
EO	Elementary/Secondary (0-12)	College (1-40)	The Laur	ndry Mach				Hospita	ıl
Be (	17. Father's Name (First, Middle, La	ast)				s Name (First, Middle			
2	Isaiah Roger D		10h 14ai	line Address (Care		cie Lucille or Rural Route Numi			Cadal
	19a. Informant's Name/Relationshi  Judith A.Davis					Aberdeen, 1	-		
	20a. Method of Disposition		20b. Place of Disp			Date	_	ion - City or To	
	1  Burial 2  Cremation 3 `4  Donation 5  Other (Spe		Harford M			11/12/05	Abeı	rdeen,	Maryland
once. To Be Completed	21. Signature of Funeral Service Li	censee		22. Name and Add	dress of Facility	moral Hom	ο P λ		
ä	Sugal	2cott		EESOT 2	orai c Ct	neral Hom ceet, Havr	C' 45 °C'	race. M	ID 21078
				JJZ 116	SMIP OCI	eet, navi	e de Gi	-400	
	23a. Part1. Enter the disease, or c shock, or heart failure. List o	omplications that caused nly one cause on each li	d the death. Do not en	nter the mode of o	dying, such as c	ardiac or respiratory	arrest,		Approximate Interval Between Onset and Death
ın al	23a. Part1. Enter the disease, or c shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death)	a. MASSIV	<sub>ne.</sub> E UPPER (	nter the mode of o	dying, such as c	ardiac or respiratory	arrest,		Approximate Interval Between
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al er	shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	a. MASSIV Due to (or as	<sub>ne.</sub> E UPPER (	nter the mode of o	dying, such as c	ardiac or respiratory	arrest,		Approximate Interval Between Onset and Death
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tan/Medical Examiner	shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. MASSIV Due to (or as b. Due to (or as c. Due to (or as d. 23c. If yes, outcome	a consequence of):  a consequence of):  a consequence of):	nter the mode of o	tying, such as c	ardiac or respiratory	arrest,		Approximate Interval Between Onset and Death UNKNOWN
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o Be Completed by Physician/Medical Examiner	shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part II. Dther significant condition	a. MASSIV Due to (or as b Due to (or as c Due to (or as d  23c. If yes, outcome 1	E UPPER ( a consequence of):  a consequence of):  a consequence of):  of pregnancy 2 Fetal death 3 t time of death 5  out not resulting in the	GASTROI  GEORGE Pregna  Other (specify)  underlying cause	Incy  given in Part I.	23e. Did 24a. Wa 24a. Wa 1   Yes of Death (Check only)	23d.  tobacco use of	Date of deliver Month  contribute to the document of the docum	Approximate Interval Between Onset and Death UNKNOWN  Bry Day Year  December of death?  Death 4 Unknown  Destruction of cause of
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ertification: To Be Completed by Physician/Medical Examiner	shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. MASSIV Due to (or as b. Due to (or as c. Due to (or as d. 23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown  1s contributing to death b  1s 28a. Date of Inju (Month, Da) ation to be 28e. Place of In	a consequence of):  a consequence of):  a consequence of):  a consequence of):  of pregnancy 2   Fetal death 3 t time of death 5  out not resulting in the  ent 2   EF/Outpati Lary 28b. Time Injury of my knowledge, de- of examination and/or	CASTROI  CASTROI  CONTROL  CON	Incy  given in Part I.  26. Place  Other: 4   Nurrinjury at Nork?  I   Yes 2   Nurrice	23e. Did 1 24a. Wa autroper 1 1 Yes of Death (Check only sing Home 5 Res 28d. Describe to 28f. Location City or To	23d.  23d.  23d.  23d.  23d.  23d.  24 No  25 No  26 No  27 No  27 No  28 No  28 No  29 No  29 No  20 No  2	Date of deliver Month  Contribute to the deliver of	Approximate Interval Between Onset and Death UNKNOWN  Bry Day Year  December of death?  Death of the Course of the Course of
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541VA

State Registrar

31. Date filed (Month, Day, Year)
NOV 0\*9 2005



Avelina Hernandez, M.D., VA Maryland Health Care System, Perry Point, MD

			1 - For State Registrar	State of Ma	arylan			ent of Hate of L		nd Me		giene Reg: No.	05	C	7698	
	Physici	an	Decedent's Name (First, Middle, La	st)						2	. Date of De Month	ath Day	Υ	ear	3. Time of Death	
	/Medic		ROBERT E. DEP								NOVEMBE		2005		6:23 P	M
	Examin Funeral	er	4a. Facility Name (If not institution, giv  LAUREL REGIONAL HOSPI  5. Social Security Number  6. S	CAL		last birthday) Yrs.	LAU	ty, Town, or IREL der 1 Year is Days	If Under 2		. Date of Bir (Month, Da	PRI		EORGE Birthpl	ace (State or Forei	gn
	Director		544=07-6367 Usual Residence of Decedent		87	115.				JŲ	JLY 28,	1918	01	REGON		
	/land	İ	10a. State 10b. County	-	10c. City	y, Town or Lo	cation							10	d. Inside City Limit	ts
	Man Firsh	to	MARYLAND MONTGOMERY		SILV	ER SPRI	NG								1 ☐ Yes 2 🖾 N	0
	n the	Directo	10e. Street and Number					Zip Code				10g. Citiz	en of Wha	at Coun	try?	
	23a (		3112 GRACEFIELD ROAD					20904	+			U.	S.A.			
9	be filed within 72 hours after death with the Maryland Hygiene. All Hygiene. A chert han "natural", or items 23a or 28a-f show do other than "natural", or items 23a or 28a-f show event, the Medical Examination must be notified.	by Funeral	11. Marital Status  1 □ Never Married 2 ☒ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1  Yes 2 16 If Yes, Give Year or Dates:				cedent of His pecify Cubar 2 \(\bar{\text{No}}\) No	spanic Origin, Mexican,  Specify:	in? (Speci Puerto Ri	fy Yes or No can, etc.)		4. Race - Black, Specify:	America White, 6	otc.	
2-003a	tural		15. Decedent's E	ducation		16a, Deced	dent's U	sual Occupa	tion			16b. Kir	nd of Busin			
C1717	i within 72 jene. r than "na ine Medir	Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5	i+)	(Give	kind of DO NOT	work done d use retired)	urina most i	of working			GOVEI		,	
Ď.	e filed Il Hygi other vent, II	BeC	17. Father's Name (First, Middle, Last,	1					18. Mother	's Name (/	First, Middle,		_			
<u> </u>	ould be   Mental harked o	ToE	CLARENCE M. DI	EPEW					MARY		DYER					
77	2 should be and Mental Is marked raumatic ev		19a. Informant's Name/Relationship (	Type, Print)		19b. Mailir	ng Addre	ess (Street a	nd Number	or Rural F	Route Numb	er, City or	Town, Sta	ate, Zip	Code)	
	1 and 3 Health tem 27 other tri		EDITH B. DEPEW/WIFE		1205 B						SPRING,				-	
baltimore,	Se to I		20a. Method of Disposition 1 🖾 Burial 2 □ Cremation 3 □		200. P	lace of Dispo emetery, crer	natory c	r other place	)	Dat	9	20c. Loc	cation - Cit	y or Io	wn, State	
	ritmer range		<ul><li>4 □ Donation 5 □ Other (Specil</li><li>21. Signature of Funeral Service Licer</li></ul>		GAT	E OF HEA				1/7/20					MARYLAND	
מ	permit. Page Department Important: If any injury or		m n n d n	Ludow	10	100					RINALD					
			23a. Part 1. Enter the disease, or com	plications that caused	the death								ING, N	ARYL	AND 20904 Approximate	
	nysician /Medical		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	aATHEROSCI	EROTI		DISE	ASE							Interval Between Onset and Death 21 DAYS	
	Examiner			Due to (or as	a consequ	uence or):										
,	ificate be executed g physician and as the burial-transit	i Examiner	Sequentially list conditions, if any, leading to immediate cause. Faur Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as												
00/00	icate b physic s the b	edical		d						-						
YOU .	death cert e attending id for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal	Ideath 3□		pregnancy (specify)				2	3d. Date o Month		y Day Year	
1 (SD )	The law requires that the te has been signed by th rage 2 should be detache	by	Part II. Other significant conditions of	ontributing to death b	ut not resi	ulting in the u	nderlyin	g cause give	n in Part I.						e cause of death?	'n
אוומו חפרטומ		Completed									24a. Was autor perfo	osy irmed?	prio dea	r to com	sy findings availab ipletion of cause of 2 \( \sum \) No	le
7	nysician: Th nis certificate director, pag	Be (	25. Was case referred to medical examiner?	Liannite I:				12		of Death (	Check only o	one)				
5	Phys this ral dii	tlon: To	1 Yes 2 X No  27. Manner of Death  1 X Natural 5 Pending 2 Accident investigation	Hospital: 1 🔀 Inpatie 28a. Date of Inju. (Month, Day	rv	ER/Outpatien 28b. Time of Injury		28c. Injury Work	4   14013	286	5 Resid. Describe			Specify,		
DIVISION	Hospital or Attending 4 hours after death. Funeral Director: After tely filled in by the fune	Certification:	3 Suicide 6 Could not b 4 Homicide determined	9 One Place of Init	ury - At ho c. (Specify	ome, farm, str	eet, fact	ory, office		281	f. Location (S City or Tox	Street and wn, State)	Number o	or Rural	Route Number,	
	To the Hospital within 24 hours a To the Funeral C completely filled	edical	(Check only 2 Medical Examone)	niner: On the best of and manner sta	examina	wledge, death tion and/or inv	vestigati	on, in my op	inion, death	place, and occurred	at the time,	date and	place, and	due to	the cause(s)	
	To To Con	Σ	29b Signature and title of certifier	lou 11				29c. License	number			29d. Date	signed (A	rionth, E	yay, Year)	
			· aurel	(XNY)				D004337	5		N	OVEMB	ER 4,	2005		
	12		30. Name and address of person who KAREN MERRITT, M.D.,					DDTNC	MADUTA	ND 200	0/2					
	Sta	te	31. Date filed (Month, Day, Year)	32. Registra		ture			IMNILA.	ND 209	<del>04</del>					
	Registr	- 3	NOV 0 7 2	2005	D 10 18	1 St	SA.	1								

ysici: Aedic	an	1. Decedent's Name (First, Middle, Las	Robert W. Ec	:k	7	,	2. Date of Dea Month	ıth Day	Year	3. Time of Death
		KUUGUL	W		- 60	4	NOVBM	b 13	5,2005	12.35
amin	er	4a. Facility Name (If not institution, give	Alice Ilsen	11	4b. City, Town, or	Location of Death			ounty of Death	
eral		5. Social Security Number 6. So	ex 7. Age (in yrs.	last birthday	If Under 1 Year	If Under 24 Hrs.	8. Date of Birtl	h	1timore	place (State or Foreigntry)
ctor		084-18-5208	⊠M 2□F 81	Yrs.	Months Days	Hours Min.	(Month, Day	, <sub>Year)</sub> • 192		ntry) York
190	Ì	Usual Residence of Decedent  10a. State 10b. County	10c Cit	y, Town or L	ocation					10d. Inside City Limit
event, the Medical Examiner must be notified at	ō									1, Yes 2 N
netit	Directo	Virginia   10e. Street and Number	Ale	exandr	10f. Zip Code			10g. Citize	n of What Cou	
व्या		5139 Holmes Run Pa	arkwav		22304			USA		
M I	Funerai	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	.S. 13	. Was Decedent of H If Yes, specify Cuba	spanic Origin? (Sp	pecify Yes or No-		Race - Ameri Black, White,	
arcillus a		1 Never Married 2 Married	1√ Yes 2 No If Yes, Give		1 ☐ Yes 2X No	Specify:	Tribari, oto.,		pecify: Whi	
A Ex	Completed by	3√ Widowed 4 □ Divorced	Year or Dates:	16a Doa	edent's Usual Occup	ntion				
Assile	piet	15. Decedent's Ed (Specify only highest gra	de completed)	(Giv	e kind of work done of DO NOT use retired	furing most of work	king	TOU. KING	of Business/Ir	idustry
U.S.	mo	Elementary/Secondary (0-12)	College (1-4or 5+)	Civ	il Enginee	er	Ţ	JS Go	vt Defe	ense Dept
vent,	Be C	17. Father's Name (First, Middle, Last)	•			18. Mother's Nam				
	To	Gunnard Eck		_		Dorothy	Atwood			
9		19a. Informant's Name/Relationship (7			ling Address (Street a					
other tr		Lynda J. Kady (Data 20a. Method of Disposition	20b. P	Place of Disc	9 Lincolny position (Name of		e., Burl		a. 220 tion - City or T	
-		1 — Burial 2 □ Cremation 3 □	Removal from State	semetery, cri	ematory or other place National	θ)	/22/05		•	
eny injury o once.		4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen				1.	_	IIIai	igre, v	IIgIIIIa
eny i		19 mars	trace	2	22. Name and Addres Jefferson 755 Castl	Funeral	Chapel	vandr	ia Va	22315
cian lical iner	cai Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated avents resulting in death) Last	b. Due to (or as a consequence of the consequence o	uence of):	ArS					Onset and Death
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ORIGINAL

		•	For State Registrar	State of Marylar		artment of H <i>tificate of I</i>			ene 0 0 5	37700
1	<b>.</b>		Decedent's Name (First, Middle, Last)					2. Date of Death Month	<del>-</del>	3. Time of Death
	Physici /Medic		Peggy Ann	Forry				Nollm	1	5 14:15 M
	Examin	er	4a. Facility Name (If not institution, give s			4b. City, Town, or	Location of Death		4c. County of Dea	th
	Funeral		124 Cat Swamp Road  5. Social Security Number 6. Sex		last birthday)	Elkton If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Cecil 9. Bir	tholace /State or Foreign
	Funeral Director		210-42-2063	M XOF 55	Yrs.	Months Days	Hours Min.	(Month, Day,	Year) Corl	thplace (State or Foreign ountry) K, PA
	land ow		Usual Residence of Decedent  10a. State 10b. County	10c. C	ty, Town or Lo	cation				10d. Inside City Limits
	Marylan 8-f ehow	tor	MD Cecil		Elkton					1 ☐ Yes 2 ☐ No
	or 28	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	ountry?
	eth w		124 Cat Swamp Road			2192			USA	
	ltam	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 X No	J.S. 13. Y	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whi	
920	ours af	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1□Yes 2☑No	Specify:		Specify:	White
21215-0036	ges 1 and 2 should be filed within 72 hours after deeth with the Maryland it of Health and Mental Hygiene.  If Item 27 is marked other then "natural", or Itame 23a or 28e-f ehow or other treumatic svent, the Medical Exacultual he milliad at	Completed	15. Decedent's Edu (Specify only highest grade	cation completed)	16a. Dece (Give	ient's Usual Occup	ation during most of worki	ng 1	6b. Kind of Business	/Industry
12	e filed within al Hygiene. I other then "	omp	Elementary/Secondary (0-12)	College (1-4or 5+)	1	aurant	1)		Food	
P	be filed tal Hygi d other	Be C	17. Father's Name (First, Middle, Last)		1.000	agranc	18. Mother's Name	e (First, Middle, M	faiden Sumame)	
ylai	should be ind Mental imarked c	To E	Arthur Lover, Sr.				Lillian I	Myers		
lan	2 sho		19a. Informant's Name/Relationship (Ty	oe, Print)	19b. Mailir	ng Address (Street	and Number or Rura	al Route Number,	City or Town, State,	Zip Code)
e,	1 and Health em 27 ther t		Jayne Whitehead 20a. Method of Disposition	20b.		at Swamp	Road, Ell		21921 Oc. Location - City or	Town State
nor	ant of l		1 Burial 2 Cremation 3 R	emovalifrom State	cemetery, crer atomy G	natory`or other plac	(e)			
Baltimore, Maryland	permit. Pages 1 and 2 Department of Health a Important: If Item 27 to eny injury or other tre gnce.		21. Signature of Funeral Service Licens						Hanover, N ral Home o	
8	Depa Impo eny ii		Kelet	reh	20	53 Pulasi	ki Highway	y, Newar	k, DE 1970	
			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that sused the dea ne cause on e ch line.	th. Do not ent	er the mode of dyin	g, such as cardiac o	or respiratory arre	st,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	Lung	Cance	r				9 months
\$	/Medical Examiner		1	Due to (or as a conse	quence of):					
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conse	quence of):					
	acuted ind transii	Examiner	Cause (Disease or injury that initiated events resulting in death) Last							
60,	ificate be executed g physicien and as the burial-transit	al Ey	resulting in death) Last	Due to (or as a conse	quence of):					
68760,	tificate og phys as the	edicai								
Вох		M/us	230. Was decedent pregnant	3c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet		Ectopic pregnancy	,		23d. Date of de	
о В	requires that the death cer been signed by the attendin hould be deteched for use	Physician/M	in the past 12 months? 1 □ Yes 2.0 No 9 □ Unknowh	4☐Pregnant at time of 9☐ Unknown		Other (specify)			Month	Day Year
, P.O.	es that the de igned by the a be deteched f	y Ph	Part II. Other significant conditions cor	ntributing to death but not re	sulting in the u	nderlying cause giv	en in Part I.	23e. Did tob	acco use contribute to	o the cause of death?
rds	w requires been sign should be	ed by						1 XYes	s 2□No 3□P	robably 4 Unknown
eco	S S S	Completed						24a. Was an autopsy	prior to	utopsy findings available completion of cause of
E								perform 1 Yes 2	ed? death? ☑No 1 ☐ Yes	s 2 No
Žį.	Physician: Th r this certificete ral director, pag	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 Ø No	lospital:	7500	. all post Oth	26. Place of Death			Brushker
ŏ	Phys er this eral di	 5	27. Manner of Death	28a. Date of Injury	ER/Outpatier 28b. Time of	28c. Injur	y at	me 5 🗌 Resider 28d. Describe hov	nce 6 X Other (Spe w injury occurred	home soity)
ion	Attending r death. ector: After by the fune	atio	1 Natural 5 ☐ Pending 2 Accident investigation	(Month, Day Year)	Injury	M 1	k? Yes 2 □No			
Division of Vital Records,		Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At I building, etc. (Spec	nome, farm, str ify)	eet, factory, office		28f. Location (Str. City or Town,	eet and Number or R State)	ural Route Number,
	Hospitel or 24 hours afte Funerel Dir stely filled in		29a. Certifying Phys	ician: To the best of my kn	owiedge, deati	occurred at the time	ne, date and place,	and due to the car	use(s) and manner a	s stated.
	the Ho in 24 the the Fu ipletely	ledical	(Check only 2 Medical Examination)	ner: On the basis of examin and manner stated.	ation and/or in	vestigation, in my o	pinion, death occurr	ed at the time, da	te and place, and due	e to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	4.3		29c. Licens	- 1-		d. Date signed (Mon	
•	10		30. Name and address of person who co	impleted cause of death (Ite	m 23a\ /Tuna	Print)	15 71	TI	overaber	3, 2005
	12		4 Far Kas Mo	Glasons /	Neill	ern C	Le saples	ke Horn	cy Elkton	MO
15/10/2	Sta Registi		31. Date filed (Month, Day, Year) NOV 0 3 2005	32. Registrar's Sign	atue			11 11		,
	negisti	ell		-						

			1- For State of Ma	aryland / Depa <i>Ce</i>	artment of He			2005	37701
	Physici	an	Decedent's Name (First, Middle, Last)			· ·	2. Date of Death	Day Ye	3. Time of Death
	/Medic		Alice Mignonette Fult	on			NOVEMBE	104, 200	05 0100 M
	Examin	er	4a. Facility Name (If not institution, give street and number)	hon't	4b. City, Town, or I	Location of Death		4c. County of D	ESTEP
	Europel		DOTCHESTER GENERAL H.  5. Social Security Number 6. Sex 7. Age	e (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		
	Funeral Director		214-12-5244 1 M 2 1 F	82 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye NOV. 20,		Birthplace (State or Foreign Country) Maryland
	pu ,		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo					10d. Inside City Limits
C	death with the Maryland ims 23a or 28e-f show r must be notified at	ō	MD Dorchester	100. Only, Town of Ec		ew Marke	t		1 ☐ Yes 2 No
Y	28e-i	Director	10e. Street and Number		10f. Zip Code		10a	. Citizen of What	Country?
Z	h with	D	5962 Heritage Road			21631		USA	
	deat	Funeral	11. Marital Status 12. Was Decedent I Armed Forces?	Ever in U.S. 13.	Was Decedent of His If Yes, specify Cuban	spanic Origin? (Sp	pecify Yes or No-		merican Indian, /hite, etc.
36	or its	by Fu	1 Never Married 2 Married 1 Yes 2 M	No I	1 ☐ Yes 2 No	Specify:	7 1.104.1, 010.7		white
Ö	hours tural'	q pa	3 ☐ Widowed 4 ☐ Divorced Year or Dates:  15. Decedent's Education	l 16a Dece	dent's Usual Occupa	tion	16	b. Kind of Busine	
15	in 72 n "na Nedic	plet	(Specify only highest grade completed)	(Give	kind of work done du DO NOT use retired)	uring most of world	king	5. Kind of Edsine	555/muustry
212	giene giene er the	Completed	Elementary/Secondary (0-12) College (1-4or 5	(+)	homemaker			own ho	me
nd	be file tal Hy d oth	Be (	17. Father's Name (First, Middle, Last)				e (First, Middle, Mai	,	
<u>Y</u> la	Men Men Marke Marke	2	Carroll Horseman				red Corbma		
Maryland 21215-0036	d 2 st th and 7 is n traun		19a. Informant's Name/Relationship (Type, Print)  Joseph M. Fulton Sr. husb		ng Address (Street ar				
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examinar must be notified at ance.		20a. Method of Disposition	20b. Place of Dispo	Heritage			c. Location - City	
E O	Pages ent of nt: If i		1 Maurial 2 □ Cremation 3 □ Removal from State '4 □ Dona on 5 □ Other (Specify)	1	matory or other place Veterans (	.	/8/05 F	Hurlock,	MD
Baltimore,	Departm Departm Importa any inju		21. Signature of Funeral Service Licensee		2. Name and Address			eral Hom	e P.A.
<u>m</u>	89 5 8		phut James		700 Locust	st., a	ambridge,	MD 216	13
			23a. Pany Enter the disease, or complications that caused show, or heart failure. List only one cause on each lin	the death. Do not ent ie.	ter the mode of dying	, such as cardiac	or respiratory arrest	1	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	10VASC4	clar y	Accid	24/		Onset and Death NIWEEK
	/Medical Examiner		Due to (or as	a consequence of):					
		er	Sequentially list conditions, if any, leading to immediate b. Due to (or as	a consequence of):					
	outed id ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events						
oʻ	e exection and an arrigal-tr		resulting in death) Last Due to (or as	a consequence of):					
8760,	death certificate be executed e attending physician and of for use as the buriat-transit	dlcal	d.						
9	leath certific attending p	/Med	IF FEMALE: 23c. If yes, outcome	of pregnancy				004 Date of	de libraria.
Вох	atten for us	clan/Me	in the past 12 months?	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	Day Year
P.O.	the the	Physi	1 Yes 2 No 4 Pregnant at 9 Unknown						
	igned by	by P	Part II. Other significant conditions contributing to death by	ut not resulting in the u	nderlying cause giver	n in Part I.	23e. Did tobac	co use contribute	e to the cause of death?
ord	w requires been sign should be	ted	Hy 12 Ten 5:04 12	deticie	4041		1 🗆 Yes	2 □ No 3 □	Probably 4 Doknown
ecc	aw S S	Completed	Hydel DideniA Usi	my / TAC	TInte	et.ps	24a. Was an autopsy	24b. Were prior	autopsy findings available to completion of cause of
<u> </u>	Th ate pag	Con	Hyperscleratic Ca	Ardio Va	15ch 141	0.84	Yes 2	death 1 □ Y	? es 20
Vita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?		Other	~	th (Check only one)		
ō	r this	To To	1 ☐ Yes 2 ☐ Thoshian	y 28b. Time o	f 28c. Injury	at	ome 5 Residence 28d. Describe how		pecify)
ion	Attending r death. sctor: After y the fune	atlor	15 Matural 5 ☐ Pending (Month, Day 2 ☐ Accident investigation	√ Year) Injury	Work	? es 2 □ No			
Division of Vital Records,	if or Attendi after death. I Director: A d in by the fu	Certification;	3 Suicide 6 Could not be determined 28e. Place of Inju	ury - At home, farm, str	reet, factory, office		28f. Location (Stree City or Town, S	t and Number or	Rural Route Number,
Ö	itai or rs afte rai Dir led in	Cer	2 Soliding, or		·				
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	edical	29a. Certifier (Check only onl) 2 Medical Examiner: On the basis only only only	examination and/or in	h occurred at the time vestigation, in my opi	e, date and place, nion, death occur	and due to the caus red at the time, date	e(s) and manner and place, and c	as stated. due to the cause(s)
	o the ithin 2 o the omple	Med	29b. Signature and title of certifier	ited.	29c. License	number / /	// 29d.	Date signed Mo	onth, Day, Year)
}	r ≤ r ŭ		I for all her	_ //	a A	144	7615	11/4	10.5
			30. Name and address of person who completed cause of de	eath (Item 23a) (Type,	Print)			1/1	000
			ILAND HIV /WARR	ViO.	100	/	BrAnk	ne o	of (Andridge
	Sta Registi		31. Days filed (Month, Day, Year) 32. Registra NOV 0 8 2005	ar's Signature	Angel 1				V
		4.		Desired State 1	A STATE OF THE PARTY OF THE PAR				

Amend item#31, perDVR G849, 11/22/05 TT State of Maryland? Department of Health and Mental Hygiene 15 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) November 5, Physician FRANCES ELIZABETH GRIMM 2005 9:28 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 7. Age (In yrs. /ast birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 😿 F Yrs 79 213-24-8311 **Director** Nov. 2, 1926 MD Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Madical Examiner must be multified at MD 1 Tyes 2X No Director Frederick Jefferson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3424 Fry Rd. 21755 USA within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 homemaker own home permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Important: if Item 27 is marked oth any liquy or other traumatic event size. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Emmert Adkins Alice Catherine Brandenburg 19a Informant's Name/Relationship (Type, Print) Sandra Grimm (Daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3424 Fry Rd., Jefferson, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑Burial /2 ☐ Cremation 3 ☐ Removal from State Reformed cemetery 11/8/05 Middletown, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License Donald B. Thompson Funeral Home 31 E. Main St., Middletown, MD 21769 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final disease or condition ASPIRATION **Physician** PNEOMOU14 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner SWALLOWING DISORDER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of) ician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a o. Physi 9 Unknown 9 Unknown ۵. Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ρ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 ☐ Yes 2 ☐ No 1☐ Yes 2 No : After this certific s funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Hipatient 2 - EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; Hospital or Attending 5 Pending investigation 1 A Natural 1 ☐ Yes 2 ☐ No death. 2 Accident the Director: 6 ☐ Could not be 3 Suicide 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Thomicide after within 24 hours a To the Funeral [ 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifies 29c. License number 29d. Date signed (Month, Day, Year) 026499 - M2) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ronald E. Miller. Frederick Memorial Hospital Frederick, MD 32. Restrar's Signature State **"0 9** 2005 Registrar

		1	For State Registrar	State	e of Ma	aryland		irtment tificate				lental Hy	gien Reg. Na		)	377	03
			1. Decedent's Name (First, Middle	, Last)								2. Date of De Month	aath Da	ıv Y	ear	3. Time o	f Death
	Physicia /Medic		Margaret B.	Gibson								Novemb	er 3	, 200	5	3:05	P M
	Examin		a. Facility Name (If not institution	, give street and	d number)					Location	of Death		40	. County of	Death		
		•	Suburban Hospi					Bet]	hesd	a If Under	24 Hrs	8. Date of Bir		lontgo			
I	Funeral		5. Social Security Number	6. Sex 1 ☐ M 212		103	a <i>st birthday)</i> Yrs.	Months	Days	Hours	Min.	(Month, Da	ay, Year,	,	Cou		
	Director	-	578-40-2656 Usual Residence of Decedent									Sept 1	3 19	102		DO	·
	land ow	ı ⊩	10a. State 10b. County			10c. City	, Town or Lo	cation							1	10d. Inside C	City Limits
	Man	tor	DC			Wash	ingto	n								1 XYes	s 2□No
	n the	by Funeral Director	10e. Street and Number					10f. Zip	Code				10g. Ci	tizen of Wha	at Cou	ntry?	
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	ems ems	ner	11. Marital Status	Arme	d Forces?	Ever in U.	S. 13. \	Was Deced	lent of Hi	spanic Or	igin? (Spi n, Puerto	ecify Yes or No Rican, etc.)	0-	14. Race - Black,			
9	or it	J. F.	1 Never Married 2 Married	ied 1 🗆 Y	es 2000 s, Give or Dates:	No		1□ Yes		Specify:				Specify:	Whi	te	
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0 0	Hygi Hygi other ent.	Be C	17. Father's Name (First, Middle,	Last)						18. Moth	er's Name	e (First, Middle	, Maide	n Sumame)			
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ary	should by many or many		19a. Informant's Name/Relations	hip (Type, Print,	)			3	•			al Route Numb			ate, Zij	Code)	
Σ	and 2 alth a 127 is er tra		Thomas Gibson	/ Son						Dr. (		en, CO	_				
ore	of He		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 □Removal f	rom State		lace of Dispo emetery, crei	sition (Nan natory or o	ne of ther plac	e)		Date	20c. L	ocation - Ci	ty or T	own, State	
<u>Ĕ</u>	Pag ment and g		° 4 ☐ Donation 5 ☐ Other (S	pecify)			e of H					2005					)
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants: if item 27 is marked other than "natural; or items 23a or 28a-f show mit you pury or other traumatic event. It a Medical Examinat must be notified at ance.		21. Signature of Funeral Service	Licensee								seph Ga				Inc.	
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			23a. Part1. Enter the disease, o shock, or heart failure. List	only one cause	on each l	d the death ine.	n. Do not ent	er the mod	ie or dyin	g, such as	cardiac	or respiratory a	arrest,			Interval Be Onset and	etween
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	/Medical Examiner		1050ttalig iii 000tti)	Du	e to (or as	a consequ	uence of):										
ь		<u>F</u>	Sequentially list conditions, if any, leading to immediate	b	e to (or as	a consequ	uence of):								+		
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Вох	death certifica e attending ph od for use as th	an/N	1F FEMALE: 23b. Was decedent pregnant			of pregna 2 Feta		∃Ectopic pi	regnancy					23d. Date of Month		ery Day	Year
		Physician/M	in the past 12 months?		Pregnant a Unknown	at time of d	eath 5[	Other (sp	pecify)					WOOT		Juy	
P.0	that the de ed by the a detached	Phy	9 Unknown  Part II. Other significant conditions	one contribution	to doath l	but not rec	ulting in the U	nderhing o	ause div	en in Part	1	23e Did	tobacco	use contrib	ute to t	he cause of	death?
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Records,	The law requires that the site has been signed by the bage 2 should be detache	Completed	Old lige									24a. Wa			are aut	opsy finding	e available
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Division	if or Attending after death. I Diractor: After d in by the fune	ifica	3 ☐ Suicide 6 ☐ Could	nined 289.		njury - At ho etc. <i>(Specif</i>	ome, farm, st	reet, factor	y, office			28f. Location City or To			or Rur	al Route Nu	mber,
Ö	at or A s after at Dirac	Certification:	4 I Homore		building, e	no. (opoui)											
	ospit hour uners ly fille		29a. Certifier 15 Certify	ng Physician: 1 I Examiner: On	To the bes	t of my kno	wledge, deal	h occurred	at the tir	ne, date a	nd place, ath occur	and due to the	e cause(	s) and mann	ner as :	stated. to the cause	(s)
	To the Hospital of within 24 hours at To the Funeral D completely filled in	Medical	one)	and	manners					e number				ate signed (			
	To To To To To To To To To To To To To T	2	29b. Signature and title of certifi	7	/	)				347				. 3,			
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	12		30. Name and address of person Marjorie Danni						P.o.	those	ร์ก ".	ത					
		ate	Marjorie Danni 31. Date filed (Month, Day, Yea							chest	ل ونت	ш					
	Regist			7 2005	E. F. St.	3,480 .	ature	Daves.									
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 15 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** November 3, 2005 Mollie GROMAN 11:25 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

June 16, 1914 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1□ M 2□√F Months New York 91 082-10-6891 Director Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits r than "natural", or items 23s or 28e-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Montgomery Rockville 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 20852 6105 Montrose Road United States Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11 Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after or ment of Health and Mental Hygiene. and the file and the file of the fil 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1□Yes 2□No Specify: à Specify: 3 X Widowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clerical Office Supply 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Hyman Gorkowitz Lena Lefkowitz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hazel Groman, Daughter 3051 Idaho Ave., NW, Washington, DC 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 □ Cremation 3 X Removal from State 11/08/05 permit. Page Department o Importent: If any injury or once. d <sup>1</sup> 4 □ Donation 5 □ Other (Specify) New Montefiore Cemetery Farmingdale, NY 21. Signature of Funeral Service Licensee Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC 20012 23a. Part1. Ender the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ISCHEMIC CARMO HYODATHY /Medical Due to (or as a consequence of) Examiner CEREBROVATCULAR ACCUBENT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4 Pregnant at time of death 5 Other (specify) Ö the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate Vital 1 ☐ Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 🛣 No this of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After sion 1 Natural 2 Accident 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours after c Funeral Direc 4 | Homicide 29a. Certifier Destrifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the within 2 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) HID. 05 D 27660 3 o completed cause of death (Item 23a) (Type, Print) 30. Name and address of person /w

State Registrar Alpana Goswami.

M.D.

MOLLIE

JAROMAN,

05

32. Registrar's Signature

11119 Rockville Pike #Gl00, Rockville, MD 20852

State of Maryland / Department of Health and Mental Hygiene 0.05Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 12:46 PM Gaither Kenneth W. 2005 30, /Medical October 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 108 Central Ave. Frederick Brunswick If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 1 XM 2 ☐ F 217-28-7084 70 Yrs Director Jan. 9, 1935 Maryland Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits or 28a-f show e notified at 10b. County 1∑Yes 2 ☐ No Maryland Frederick Brunswick Directo 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? r than "natural", or iteme 23s or the Medical Examiner is untibe 108 Central Ave. 21716 United States Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status ∏Yes 2 ☐ No f Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No ð Specify: White 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education othar 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) .. Pages 1 and 2 should be fil tment of Health and Mental H tant: if item 27 is marked otl jury or other traumatic even Be Paul W. Gaither Mamie Barger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rita Webber / Sister 11 East 8th Street, Brunswick, MD 21716 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: if eny injury or once. 11/3/2005 Park Heights Cem. Brunswick, Maryland 22. Name and Address of Facility Stauffer Funeral Home 21. Signature of Funeral Service Licensee 1100 North Maple Ave., Brunswick, MD <u> 21716</u> tau Rart1. Enter the disease or complications that bused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause de each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** herosclerot ear /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certiticate be executed resulting in death) Last Due to (or as a consequence of): O. Box 68760, Completed by Physician/Medical attending | IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by the Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 Yes 1 🗌 Yes 2 A No Un Be 25. Was case referred to medical 26. Place of Death | Check only one examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Inpatient 2 ER/Outpatient 3 DOA this I Director: After this d in by the funeral d 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Vanner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 | Yes 2 | No death 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after or To the Funeral Direct completely tilled in by 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number use of death (Item 23a) (Type, Print) 30. Name and address of person who Sola

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

**NOV 0 7** 2005

32. Raistrar's Signature

For

State of Maryland / Department of Health and Mental Hygiene 15

			1 - State Registrar		Ce	rtificate of I	Death	F	Reg. No.		
			1. Decedent's Name (First, Middle, I	.ast)				2. Date of Dea	ath		3. Time of Death
	Physici		Austin Juni	us Hurle	€V			Novemb	er 5,20	05°	8:55 P M
	/Medic Examir		4a. Facility Name (If not institution, g			4b. City, Town, or	r Location of Death		4c. County		
	LAGIIII		902 Roslyn Ave	enue		Camb:	ridge		Do	orche	ester
	Funeral			Sex 7. Ag	e (In yrs. last birthday	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	h Vaarl	9. Birth	place (State or Foreign
	Director		220-03-0016 Usual Residence of Decedent	15 <b>K</b> M 2□F	88 Yrs.	Months Days	Hours Min.	Dec. 1	, 1916	Mary	yland
_	land ow		10a. State 10b. County		10c. City, Town or L	ocation				1	10d. Inside City Limits
Ç	Many	ξ	MD Dorch	nester		Ca	mbridge				1XYes 2 No
7	28a	rec	10e. Street and Number			10f. Zip Code			10g. Citizen of V	Vhat Cou	ntry?
3	death with the Maryland me 23a or 28a-f ehow r must be notified at	Funeral Director	902 Roslyn Ave	enue		2	1613		USA		
0	me 2	era	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of H If Yes, specify Cuba		ecify Yes or No-		e - Ameri	can Indian,
36	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If item 27 is marked other than "natural", or Itame 23a or 28a-f show or other treumatic event, the Medical Examinar must be notified at	by Fur	1 ☐ Never Married 25 Married 3 ☐ Widowed 4 ☐ Divorced			If Yes, specify Cuba 1 ☐ Yes 2 No	Specify:	Hican, etc.)		k, White, wh	
215-0036	72 hou	Completed	15. Decedent's (Specify only highest)	Education rrade completed)	16a. Dece	edent's Usual Occup e kind of work done of DO NOT use retired	ation during most of work	ing	16b. Kind of Bu	usiness/In	dustry
121	within ene. then "	ш	Elementary/Secondary (0-12)	College (1-4or	5+) _	uilding c	•		cons	truct	ion
121	filed Hygie Hygie of the r		17. Father's Name (First, Middle, La	st)		diraing c	18. Mother's Name				21011
Maryland	ould be 1 Mentai I larked o	Be	Riley Hurley					ine Hen		,	
2	should nd Men marke	2	19a. Informant's Name/Relationship	(Type Print)	19b Mail	ing Address (Street				State Zir	Code)
Sa	id 2 sho th and the m		Martha Hurley	wife		Roslyn Av					,
a)	of Health of Health litem 27 i		20a. Method of Disposition	WILE	20b. Place of Disp	osition (Name of		Date	20c. Location -	613 City or To	own, State
Baltimore,	Pages nent of i ent: if it		1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe		Maryland		Cem. 11/	8/05	Hurlock	•	
Balt	permit. Page Depertment of Importent: if any injury or once.		21. Signatura il Funeral Se use Lic	ensee	2	2. Name and Addres	ss of Facility Th st St., C			ome E 21613	
			23a. Part1 Enter the disease, or co short, or heart failure. List on	mplications that cause	the death. Do not er	ter the mode of dyin	g, such as cardiac	or respiratory ar	rest,		Approximate Interval Between
	Physician		Immediate Cause (Final	A4	1-1-1						Onset and Death
7	/Medical		disease or condition resulting in death)	a	a consequence of):	ng cerci	noma			_	5 years
	Examiner				,						,
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	a consequence of):						
	uted d ansit	Ē	Cause (Disease or injury that initiated events								
Ć.	execun an an ial-tr	Examin	resulting in death) Last	Due to (or as	a consequence of):						
68760,	certificate be executed ding physician and se as the burial-transit	cai		d							
68	ufficat g phy as th	/Medical									
O. Box	The law requires that the death certific tite has been signed by the attending p bage 2 should be detached for use as i	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Dat Mo	e of delive	ery Day Year
Ω.	that ned by deta	Ph/	Part II. Other significant conditions	contributing to death b	out not resulting in the	underlying cause give	en in Part I.	23e. Did to	bacco use conti	ribute to t	ne cause of death?
ds	uires sign ld be	d b	Chroniz obstruct	ive onlymons	re diceace			1 🖼 Y	es 2 No	3 Prob	ably 4 Unknown
Ö	w requires to been signer should be	ete	14 1.1-,	0,	100			24a, Wasa	n 24h 1	Mara auto	ney findings available
of Vital Records,		Completed by	Atherosclerotic	ard lonascu	iar vislase			autop perfor	med?   c	rior to co leath?	psy findings available mpletion of cause of 2 No
ita	Phyeicien: Th this certificate ral director, pag	Be (	25. Was case referred to medical examiner?				26. Place of Death	(Check only o	10)		
) V	dis y	9	1 ☐ Yes 2 ☑ No		ent 2 ER/Outpatie	nt 3 DOA	4   Nursing Ho				y)
ion o	ding h. After fune	ation:	27. Manner of Death  1 ★Natural 5 Pending 2 Accident investigat	28a. Date of Inju (Month, Da	y Year) 28b. Time ( Injury	Worl		28d. Describe h	ow injury occurr	ed	
Division	e Hospitei or Attendi 24 hours after death. • Funerei Director: A etely filled in by the fu	Certification:	3 Suicide 6 Could not	289. Place of in	ury - At home, farm, si c. <i>(Specify)</i>	reet, factory, office		28f. Location (S City or Tow	itreet and Numb n, State)	er or Rura	l Route Number,
	To the Hospitei or Attenwithin 24 hours after death To the Funerei Director:	edical C		Physician: To the best aminer: On the basis of and manner st	f examination and/or it						
	To the Vithin 2 To the Complet	Me	29b. Signature and title of certifier	0//	110	29c. License	a number	2	29d. Date signed	(Month,	Day, Year)
)			D 0 0	100	KK M	D	50804		Novem	ber 8	3,2005

Registrar DHMH 17 Rev 1/2001

State

408 Byrn Street

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D. 0 8 2005

31. Date filed (Month, Day, Year)

			For State Registrar	State of	of Maryland		artment of H			ene 2. No. 0 5	37707
	- 11		Decedent's Name (First, Midd	le, Last)					2. Date of Death	1	3. Time of Death
	Physicia		DEWEY HALI	ī.					Month NOVEMBER	Day Ye 4. 2005	1:15 P M
	/Medic Examin	ar i	4a. Facility Name (If not institution		ımber)		4b. City, Town, or	Location of Death	110,111	4c. County of D	
	LXamin	· ·	HOMEWOOD AT CRUMLA	ND FARM			FREDERICK			FREDERIC	K
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Vear) 9.	Birthplace (State or Foreign
	Director		265-05-7996	1 🖾 M 2 🗆 F	87	Yrs.	Months Days		OCTOBER 17		ORIDA
	D .		Usual Residence of Decedent		7 42 20						
	trylar	_	10a. State 10b. County	4	10c. City	, Town or Lo	cation				10d. Inside City Limits
	Sa-f.	5	MARYLAND FREDER	ICK	FREDI	ERICK					1 🔀 Yes 2 🗌 No
	or 24	Director	10e. Street and Number				10f. Zip Code		10	g. Citizen of Wha	t Country?
	23e		740 WILLOW ROAD, A				2170			U.S.A.	
	tems	Funeral	11. Marital Status	Armed F		S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		American Indian, Vhite, etc.
36	within 72 hours after death with the Maryland ene. Then "neturel", or Items 23e or 28e-f show the Moulou Examitier must be notified at	by F	1 ☐ Never Married 2 🐼 Ma 3 ☐ Widowed 4 ☐ Divorce	If Yes, G	2 □ No ive Dates: WWII		1 ☐ Yes 2 🖾 No	Specify:		Specify; WH	TTE
21215-0036	"neturel", or			nt's Education	Dates: WWII	16a Daca	dent's Usual Occupa	ation		6b. Kind of Busin	
15	be filed within 72 ho ital Hygiene. vd other then "netul event, II v M. Jir.	Completed	(Specify only high	est grade completed,		(Give	kind of work done of DO NOT use retired	during most of work	ing	OD. PAING OF DUSING	ossiniaustry
12	with ene. ther	mc	Elementary/Secondary (0-12)	College (	(1-4or 5+)	ENGINE	7R		M	ERCHANT MA	RINE
9	filed Hygid ther ant, I		17. Father's Name (First, Middle			LINGTINE	-IIC	18. Mother's Nam	e (First, Middle, N		ICIND
an	should be filed within and Mental Hygiene. marked other then imatic event, It a.M.	To Be	ISIAH HAL	Τ.			Ì	MARY	MILLS		
Maryland	s 1 and 2 should be fi f Health and Mental H item 27 is marked ot other traumatic ever	-	19a. Informant's Name/Relation			19b. Mailir	ng Address (Street a			City or Town, Sta	te, Zip Code)
Z	and 2 sealth ar n 27 is		DEBORAH H. WILLS/D.	AUGHTER		2733 1	N. 23RD ROAL	O. ARLINGTO	N. VIRGINI	A 22201	
ē,	of Health item 27 other tra		20a. Method of Disposition		20b. P	ace of Dispo	sition (Name of			Oc. Location - City	or Town, State
o L			1 ☐ Burial 2 🖾 Cremation 1 ☐ Donation 5 ☐ Other (		State	-	matory or other plac		/200E D	DENTELOOD	MA DVI AND
Baltimore,		'	21. Signatuse of Funeral Service		FOR.		LN CREMATORY  Name and Addres	. = .00		RENTWOOD,	
Ba	permit. Departr Importa any inj		1 Amanda	2 Lud	01170			11111		FUNERAL H	MARYLAND 20904
130			23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complications that	caused the death						Approximate
	5 VI		shock, or heart failure. Lis Immediate Cause (Final	st only one cause on	each line.		,				Interval Between Onset and Death
	Fny <del>sici</del> an /Medical		disease or condition resulting in death)	a	/ H						El Manta
	Examiner			Res	o (or as a consequ	-	emma				1 1120 4
		ē	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	b. Due	(or as a consequ		-chudus				1 Weak
	uted I Insit	min	Cause (Disease or injury that initiated events	Ata	red fil	2011-7	3-				SURO
Ć,	exection and ial-tra	Examin	resulting in death) Last	Due to	(or as a consequ	uence of):					8
8760,	cate be executed physician and the burial-transit	dlcal		d							
68		a)									
Вох	andin use	N	IF FEMALE: 23b. Was decedent pregnant		utcome of pregna		Testonio programa			23d. Date of	-
m	that the death certific ed by the attending p detached for use as	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Preg	birth 2 Fetal nant at time of de		<pre>JEctopic pregnancy J Other (specify)</pre>			Month	Day Year
Ö.	t the by the ache	hys	9 Unknown	9 Unki	nown						
٦,	The law requires that the death certifi tte has been signed by the attending page 2 should be delached for use a	Completed by Physician/M	Part II. Other significant condit		death but not resu	ılting in the u	inderlying cause give	en in Part I.	23e. Did tob	acco use contribu	te to the cause of death?
rd	w require been sig should b	edt	DN112	U					1 ☐ Ye	s 2 No 3	Probably 4 Minknown
Records,	s been s shoulk	plet	CAO						24a. Was ar	24b. Wer	e autopsy findings available
Re	The lav	шо							autopsy perform	ed? deat	to completion of cause of h? Yes 2 ☐ No
Vital		Be C	25. Was case referred to medic	al				26. Place of Deat	h (Check only one	7	
>		0	examiner? 1 Tes 2 XVIII	Hospital:	Inpatient 2	ER/Outpatier	nt 3 DOA Othe	er: 4 Vursing Ho	ome 5 Reside	nce 6 Other (	Specify)
1 of		n: T	27. Manner of Death	28a. Date	of Injury nth, Day Year)	28b. Time o	f 28c. Injury World		28d. Describe ho		
ion	Attending F r death. sctor: After by the funer	atio	1 Pend 2 Accident inves	tigation	nin, Day 16ar)	injury		Yes 2□No			
Division	Atte er deg ecto by th	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deter	mined 288. Plac	e of Injury - At ho	me, farm, st	reet, factory, office		28f. Location (Str. City or Town	eet and Number o	r Rural Route Number,
ā	el or s afte el Dir	Sert	4 Difficios	Built	unig, acc. (Opacii)	7			ony or roun	, Olato)	
	bspit hour uner ly fille			ing Physician: To the							
	24 24 etel	edical	(Check only 2 Medics one)	il Examiner: On the and ma	nner stated.	and/or in					
	4 5 4 4		DON COMMENTS and title of contil	ier			29c. License	e number	29	d. Date signed (N	fonth Day Year)
	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	Σ	29b. Signature and title of certif	1						11 1 .	
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	M	> Marches	Preie, 1	10		D 4	6248		11/4/05	
	./	M	30. Name and address of perso	Preie, 1		23a) (Type,		6248		11/1/05	
	To the within To the compl	W	> marched	Proving 1	use of death (Item		Print)			"/1/05	
	./	M	30. Name and address of perso	D., 300 WEST	use of death (Item	ET, FRE	Print) DERICK, MAR			"/4/05	

Dewey Hall

			tment of Health and Mental I	2000 31100
		Decedent's Name (First, Middle, Last)	2. Date o	Reg. No.  f Death 3. Time of Death
Physic		Eloise Trice Harding	Month Novem	Day Year
/Med Exami			4b. City, Town, or Location of Death	ber 4, 2005 6:50 P 4c. County of Death
		Wilson Health Care at Asbury	Gaithersburg	Montgomery
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year   If Under 24 Hrs. 8, Date o	f Birth Day, Year)  9. Birthplace (State or Foreign Country)
Director		222-18-6399 1 M 2 F 94 Yrs.		9,1911 Maryland
pug &		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Locat		
sho	5	Tod. State	tion.	10d. Inside City Limits 1 ☐ Yes 2 ☑ No
the M	Director	Maryland Montgomery Rockvi  10e. Street and Number	.11e 10f, Zip Code	
death with the Maryland ms 23a or 28e-f show Linnel be neithed at				10g. Citizen of What Country?
leath	Funeral	4003 Wild Grape Court  11. Marital Status 12. Was Decedent Ever in U.S. 13. Wa:	20853	r No- 14. Race - American Indian.
fler d	Ξ	Armed Forces? If You have Married 2 Married 1 Yes 2 No	as Decedent of Hispanic Origin? (Specify Yes o es, specify Cuban, Mexican, Puerto Rican, etc.	Black, White, etc.
orins a	by	3 ☑ Widowed 4 □ Divorced	∃Yes 2. No Specify:	Specify: White
vithin 72 hours after ene.  within 72 hours after ene.  than "natural", or ite than "natural".	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kin	nt's Usual Occupation	16b. Kind of Business/Industry
Me ithin	npie	Elementary/Secondary (0-12) College (1-4or 5+)	nd of work done during most of working NOT use retired)	
nd z l z l e filed within al Hygiene. l other than "	Co	5+ Teach	er	Education
IBING ZIZIS-UUSD Id be filed within 72 hours after death with the Marylar ental Hygiene. ked other than "natural", or items 23a or 28e-f show ic event, the Medical Exercities invisite inclified at	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Mic	ddle, Maiden Surname)
Dartimore, Maryland Z permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygis Important: if item 27 is marked other tany injury or other traumatic event, in once.	2	Herbert Trice	Mary Estelle	
Mar d 2 sh th and th and 17 is rr traum			Address (Street and Number or Rural Route Nu	ımber, City or Town, State, Zip Code)
Ce, III		Lorraine E. Harding Daughter 4003 W 20a. Method of Disposition 20b. Place of Disposition		ville, Maryland 20853
or of F		20a. Method of Disposition  1 Saurial 2 Cremation 3 Removal from State  1 Departing 5 Other (Cognity)  Care of Pieze of Disposition  Cametery, crematic  Cate of Hea	tory or other place)	20c. Location - City or Town, State
Daltimore, bermit. Pages 1 ar Department of Hea mportant: if item iny injury or othe	4	Ce	emetery Nov.7.2005	Silver Spring, Maryland
Dailling permit. Pa Departmen Important: any injury		Fra:	Name and Address of Facility Incis J. Collins Funer	al Home. Inc.
		500	University Blvd., W.,	Silver Spring,MD 20901
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter to shock, or heart failure. List only one bause on each line.	the mode or dying, such as cardiac or respirato	ry arrest, Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. Adult Failure to Th	nrive	5.183. d. 7 50dill
Examiner		Due to (or as a consequence of):  Dysphaqia		
	-a	Sequentially list conditions, b.		
ited	nin.	Cause (Disease or injury	ity	
ou, be executed ician and burial-transit	Examiner	that initiated events c.  resulting in death) Last  Due to (or as a consequence of):		
6 / OU, sate be executed ohysician and the burial-transit	dicai	d		
The Cords, P.O. BOX 08/ The law requires that the death certificate ate has been signed by the attending phys page 2 should be detached for use as the	ledi			
DOX O	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the prot 12 mouths?  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ect	ctopic pregnancy	23d. Date of delivery
ne deat the ath	sicia	1 Yes 2 No 4 Pregnant at time of death 5 Ot	hther (specify)	Month Day Year
that the de bed by the detached	hys	9 Li Onknown		
igned by be detact	by F	Part II. Other significant conditions contributing to death but not resulting in the unde	erlying cause given in Part I. 23e. D	oid tobacco use contribute to the cause of death?
w requires to been signed should be	ted		1	☐ Yes 2☐No 3☐ Probably 4☐ Unknown
lawr as be 2 sh	Completed			Vas an 24b. Were autopsy findings available utopsy prior to completion of cause of
	Con		р	erformed? death?
VICAL ician: 1 certifical ector, p	Be (	25. Was case referred to medical examiner?	26. Place of Death (Check or	nly one)
Physic this co	2	1 ☐ Yes 2 🗷 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient		desidence 6 Other (Specify)
INISION OF I or Attending Phy after death. Director: After this in by the funeral of	on:	27. Manner of Death 1 Sanatural 5 Pending (Month, Day Year) 28. Date of Injury 28b. Time of Injury	28c. Injury at Work? 28d. Descri	be how injury occurred
Attendi	cati	2 Cuiside 6 Could not be	M 1 Yes 2 No	
or At or At or At or At or At or At or At or At or At or At or At	Certification:	4 Homicide  4 Homicide  4 See Place of Injury - At home, farm, street, building, etc. (Specify)	, factory, office 28f. Location City or	n (Street and Number or Rural Route Number, Town, State)
pitei ours a eral I		29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death on	<u>\</u>	
To the Hospitei or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	29a. Certifier  (Check only one)  1	ccurred at the time, date and place, and due to tigation, in my opinion, death occurred at the tir	the cause(s) and manner as stated.  ne, date and place, and due to the cause(s)
o the	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
► S ► Ö		> HRabert Brachbanda	8 0/115	
. 43		30. Name and address of person who completed cause of death (Item 23a) (Type Print	04115	November 5,2005
10			11 Avenue Gaithersbu	rg, MD 20877
	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature		20011
Regist	rar	NOV 0 7 2005 Segre 15 Apres	de	

State of Maryland / Department of Health and Mental Hygiene 15 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** EDWARD F. HANSELL "A 000 2005 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 326 Fox Road Residence: Havre de Grace Harford 8. Date of Birth (Month, Day, Year) Jan. 22, 1 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sev 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1⊠M 2□F 85 Yrs 1920 West Virginia Director 219-05-4760 Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits item 27 is marked other than "naturel", or items 23a or 28a-1 show other treumstic event, the Medical Examinatings the restition in 1 ☐ Yes 2 € No Director Havre de Grace Maryland Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 326 Fox Road 21078 U.S.A. death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 72 hours after 1 Tyes 2 □ No
If Yes, Give
Year or Dates: 1941-45 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed withIn Hygiene. V.A. Medical Center Elementary/Secondary (0-12) College (1-4or 5+) Warehouse Supervisor Perry Point, Maryland Twelve Years and Mental Hygie is marked other permit. Pages 1 and 2 should be file Department of Heath and Mental Hy Important; if item 27 is marked other any injury or other treumatic access. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward Franklin Hansell, Sr. Virginia Allamong 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 326 Fox Road, Havre de Grace, Maryland Helen M. Hansell (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 11/05/05 <sup>¹</sup> 4 □ Donation 5 □ Other (Specify) Harford Memorial Gardens Aberdeen, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Metastones **Physician** year /Medical Due to (or as a consequence of): **Examiner** Con me Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner lecords, P.O. Box 68760, Siaw requires that the death certificate be executed. burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medicai the use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) the detached þ s been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed Thei certificete 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 X No or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 ☐ Yes 2 No this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Medical Certification: 1. Natural 2 Accident 5 Pending within 24 hours efter death. To the Funerel Director: A investigation 1 ☐ Yes 2 ☐ No completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29b. Signature and Itle of certifie 29c. License number 29d. Date signed (Month, Day, Year) D24356 Nov. 3 2005 Bel Air Oncity Bright Oaks Courtyans ted cause of death (Item 23a) (Type, Print) WATERALELD MM 2021B Emmorton Rd, Suite 212 m C 2005<sup>32. Registrar's Signature</sup> 31. Date filed (Month, State Registrar

	• ,	•	For State	State of Mary		epartment of H Certificate of I		lental Hygien	000	37710
	Physicia	an l	Registrar  1. Decedent's Name (First, Middle, Last)					2. Date of Death	ay Year	3. Time of Death
	/Medic	al	4a. Fecility Name (If not institution, give	Richard De	onald		Location of Death	November	c. County of Dea	
	Examin	er Æ	Washington County				rstown		Washi	ngton
	Funeral		5, Social Security Number 6, Se:	7. Age (In	yrs. last birth	Months Davs	II Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year	9. Bir	thplace (State or Foreign ountry)
	Director	2	220-18-1544 Usuel Residence of Decedent	ZW 201	80 <sup>†</sup>	rs.		January 24	, Ma	ryland
	yland		10a. State 10b. County	100	c. City, Town	or Location				10d. Inside City Limits
	B Mar	ctor	Maryland Frederic	k	M	yersville				1 ☐ Yes 2 🛣 No
	death with the Maryland ms 23e or 28e-f show r must be notified at	Directo	10e. Street and Number			10f. Zip Code		10g. C	itizen of What C	ountry?
	s 23e		20 Harp Place P.O	. Box 72 12. Was Decedent Ever	in II S	2177 13. Was Decedent of H		ecify Yes or No-	U.S.A. 14. Race - Am	erican Indian
0	ritem rritem	Funerai	11. Marital Status 1 ☐ Never Married 2 ☒ Married	Armed Forces? 1 XYes 2 □ No	III 0.3.	If Yes, specify Cuba	іл, Мехісал, Риело	Rican, etc.)	Black, Whi	
2-003p	rai, o	ğ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 No	Specify:		Specify: W.	hite
<u>ر</u>	72 h	Completed	15. Decedent's Edu (Specify only highest grad	cation e <i>completed)</i>		Decedent's Usual Occup (Give kind of work done of life. DO NOT use retired	durina most of work	ing 16b.	Kind of Business	/Industry
7	within Bne. then	duc	Elementary/Secondary (0-12) 12	College (1-4or 5+)		echanical E	,		Governm	ont
0	Hygi other	0	17. Father's Name (First, Middle, Last)		12	ecnamicai D		e (First, Middle, Maide		enc
yland	uld be Venta Irked Itic ev	To B	Elmer Harp				Grace	Gouker		
Mar	2 sho and h		19a. Informant's Name/Relationship (Ty	rpe, Print)	. 1	Mailing Address (Street		22.007		
2 (a)	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If time 27 is marked other then "natural; or items 23a or 28a-f show any injury or other traumatic event, the Midical Examinar must be notified at once.		Gloria L. Harp (W. 20a. Method of Disposition	ife)		Harp Place Disposition (Name of			rille, M. Location - City or	
aitimore,	ages nt of th :: If ite	H	1 ☐ Burial 2 ☐ Cremation 3 ☐ F	Removal from State	cemetery	r, crematory or other place	Nove	ember		
	nit. Partme artme ortani injury		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licens		SIIII CIIS	burg Cremat  22. Name and Addre		J.L. Dav	thsburg vis Fune	, Maryland ral Home
ñ	Dep pan yus ono		Toller for	Davis M	01414	12525 Brad	bury Ave.			
г		_	23a. Part1. Enter the disease, or complishock, or heart failure. List only of	ications that caused the	•	ot enter the mode of dyin	g, such as cardiac	or respiratory arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	. Pre	mon	ia				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a co	nsequence o	1):				
		e.	Sequentially list conditions, if any, leading to immediate	Due to (or as a co	nsequence o	1):				
H	uted d ansit	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events							
j J	e exection en anial-tr		resulting in death) Last	Due to (or as a co	nsequence o	f):				
8/60	cate be executed physicien end i the burial-transit	dicai		d						
٥			IF FEMALE:	23c. If yes, outcome of p	regnancy				23d. Date of de	Nive D.
X Q Q	ires that the death certifi signed by the attending d be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1 \( \subseteq \text{Yes}  2 \subseteq \text{No} \)	1 Live birth 2 ☐ 4 Pregnant at time	Fetal death	3 ☐Ectopic pregnancy 5 ☐ Other (specify)	1		Month Month	Day Year
j.	t the c by the tached	hysi	9 Unknown	9□ Unknown						
λ, T	requires that the een signed by th hould be detache	by P	Part II. Other significant conditions co			1	en in Part I.			o the cause of death?
ora	w require been si should I		Chronic obstr.	octive lu	150	1 sease		Yes	2 ∐ No 3 ∏ P	robably 4 Unknown
Kecords,		Completed						24a. Was an autopsy performed?	24b. Were a prior to death?	utopsy lindings available completion of cause of
<u>=</u>	hysician: The law his certificete has b I director, page 2 s		OF Mes area relayed to modical					1 Yes 2 N		s 2□No
Vita	rsicia: s certil	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: Inpatient	2 ER/Out	patient 3 DOA Oth	er:	h (Check only one) me 5 Residence	6 ∏Other (Spe	acifu)
וסר	ig Phys ter this neral di		27. Manner ol Death	28a. Date of Injury (Month, Day Ye	28b. T			28d. Describe how int		, any
Sior	endin eath. or: Aft	atio	1 Natural 5 Pending 2 Accident investigation	(			Yes 2 □No			
DIVISION	or Attending Physician: after death. Director: After this certific in by the funeral director,	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of tnjury building, etc. (S	At home, far pecify)	m, street, factory, office		28f. Location (Street a City or Town, Sta	and Number or R ite)	ural Route Number,
	spitai ours a nerai f		29a. Certifier	sician: To the best of m	v knowledge	death occurred at the tir	ne, date and place.	and due to the cause(	s) and manner a	s stated
	To the Hospital or Attending Physical within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral di	Medical	(Check only 2 Medical Exami	ner: On the basis of exa and manner stated.	mination and	Vor investigation, in my o	pinion, death occur	red at the time, date a	nd place, and du	e to the cause(s)
	To ti To ti comp	Σ	29b. Signature and title of certifier			29c. Licens	e number	29d. D	ate signed (Mon	th, Day, Year)
	/			-		100	>4451	No	vember	13, 2005
	6		30. Name and address of person who d	- 770	(Item 23a) (	Type, Print)	leval	Smith ch.	10 N	Paraload
35	Sta	te	31. Date liled (Month, Day, Year)	32. Registrar's	Signature	del.	a con or	ANUTIONO.	11	- flatel
10	Registr		NOV 2 1 2005	Heren D.	14					

			1 - For State Registrar	State of Maryland		rtment of H tificate of L			gienen	5 37711
	Physici /Medic		1. Decedent's Name (First, Middle, Last) ROBERT LEE JONES					2. Date of De. Month October	ath Day 31, 200	3. Time of Death 1:48 p
	Examin		4a. Facility Name (If not institution, give s Shady Grove Advent:			4b. City, Town, or Rockvill			4c. County	of Death
*	Funeral Director	•	5. Social Security Number 6. Sex	7. Age (In yrs. la	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		y, Year)	9. Birthplace (State or Foreign Country) 'irginia
Maryland 21215-0036	o filed within 72 hours after death with the Maryland Hygiene. Other than "natural", or ltems 23a or 28e-f show other than "natural", or ltems 23a or 28e-f show ont, I'm Medical Examination medical confiled at	To Be Completed by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Moivorced  15. Decedent's Educ (Specify only highest grade) Elementary/Secondary (0-12) 12  17. Father's Name (First, Middle, Last) John Bernard  19a. Informant's Name/Relationship (Type	Rocky  2. Was Decedent Ever in U.S. Armed Forces? Was so 2 No Kore If Yes, Give Year or Dates: ation completed)  College (1-4or 5+)	S. 13. V If If If If If If If If If If If If If	10f. Zip Code 20852  Vas Decedent of Hi Yes, specify Cuba  Pes 2000  In Yes 2000  ON OT use retired  Cuction W	n, Mexican, Puer Specify:  ation furing most of wo.  Orker  18. Mother's Nar  Dorothy  and Number or Rich	Specify Yes or No to Rican, etc.)  rking  me (First, Middle, Holt  ural Route Numbe	10g. Citizen of W United S  14. Race Black Specify:  16b. Kind of Bu  Constru Maiden Sumame	10d. Inside City Limits  1
ē S	s 1 and 2 f Health a ftem 27 is		Bobby Jones – Son  20a. Method of Disposition	00	ace of Dispos	ition (Name of		ley, Gat		WV 24941 City or Town, State
baitimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any niury or other traumatic evone.		1 Burial 2 XCremation 3 Re 4 Donation 5 Other (Specify)  21. Signature of Funeral Service License	Fort	Linco	oln Crema Name and Addres Re, Rock	tory 11-	-03-2005 mple Tri	Brentwoo	
08/00,	Physician physician and physic	edical Examiner	23a. Part 1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last  d.	Due to (or as a consequence of the consequence of t	ence of):	5 4	rate.	y d	taile	Approximate Interval Between Onset and Death Ose and Death
O. BOX	w requires that the death certif been signed by the attending should be detached for use as	Physician/Me	IF FEMALE: 23 b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	c. If yes, outcome of pregnar 1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown	death 3 □	Ectopic pregnancy Other (specify)			23d. Date Mon	e of delivery th Day Year
cords, r	requires that the een signed by th hould be detache	by	Part II. Other significant conditions conf	ributing to death but not resul	lting in the un	derlying cause give	on in Part I.	23e. Did to	1	bute to the cause of death?  3 Probably 4 Unknown
•	n: The law re ficate has be or, page 2 sho	e Completed	25. Was case referred to medical					1 Tes	med? de 2000 1	Vere autopsy findings available rior to completion of cause of eath?
DIVISION OF VI	To the Hospitel or Attending Physicien: The law winn 24 hours after death.  To the Funerel Director: After this certificate has a completely filled in by the funeral director, page 2 secondiness.	Certification; To Be	examiner?		ER/Outpatient 28b. Time of Injury	28c. Injury Work M 1 Y	4 □ Nursing H		lence 6 Othe	
-	To the Hospitel within 24 hours a To the Funerel completely filled	Medical Co	29a. Certifier (Check only one)  29b. Signature and title of certifier	cian: To the best of my know er: On the basis of examination and manner stated.	on and/or invi	estigation, in my op 29c. License	number	irred at the time, o	date and place, as 29d. Date signed	(Month, Day, Year)
	2 Sta Registr		30. Name and a dress of person who cor 31. Date filed (Month, Day, Year)	npleted cause of death (Item  Q ( 2 )  32. Registrar's Signatu	23a) (Type, F	Print)	11162	SCIR	ranta	20874

		State of Maryland / Department of Health and Mental Hygie	200
		Cortificate of Death	2005 37712
Physicia /Medica		1. Decedent's Name (First, Middle, Last)  Hazel Irene James  2. Date of Death Month No VEMDE	Day Year / 3. Time of Death / 1600 M
Examine		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	4c. County of Death
Funeral		Dorchester General Hospital Combridge  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Wunder 24 Hrs. 8. Date of Birth	Dorch Ester
Director		5. Social Security Number  6. Sex 1	(ear) 9. Birthplace (State or Foreign Country) 22, 1917 Maryland
Maryland f show	ō	10a. State 10b. County 10c. City, Town or Location  MD Dorchester Cambridge	10d. Inside City Limits 1   ✓ Yes 2   No
with the	Direc		). Citizen of What Country?
be filed within 72 hours after death with the Maryland tall Hygiene. Id other then "neturer", or items 23e or 28e-f show event. I've Medical Erain in minister rudified at	Funeral Director	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married  12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
Z Z Z D-UU36 d within 72 hours aft glene. The Medical Erand	ò	3 55 Vildowed 4 Divorced Year or Dates:	Specify: white
within 72 ne.	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  (Give kind of work done during most of working life. DO NOT use retired)	b. Kind of Business/Industry
filled v Hygie ont, in	္သ	6 homemaker  17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Mai	own home
e d la la	To Be	Frank Willey Mary Virginia L	·
Fre, Maryl2 st and 2 should of Health and Mer tiem 27 is marke other treumatic		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, C.  19b. Mary Marylsot Dhodondala	
_ c= % L		Robert L. James Sr. son 4378 East New Market Rhodesdale  20a. Method of Disposition  20b. Place of Disposition (Name of cemetary, crematory or other place)  Date 20c	c. Location - City or 1490, Sta2-1631
		12 Definal 2 Defendation of the movement of the state	mbridge, MD
Baltimore, permit. Pages 1 ar Department of Hee Importent: If item any injury or othe 2009.		21. Signatured Funeral Savrice Licensee  22. Name and Address of Facility  Thomas Fune	eral Home P.A.
<b>%</b>		23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate
Physician		Immediate Cause (Final disease or condition resulting in death)  a. Rowel Ischemit	Interval Between Onset and Death
/Medical Examiner		Due to (or as a consequence of):	
pe tis	liner	Sequentially list conditions, if any, leading to immediate ause. Enter Underlyin Due to (or as a consequence of):	
be executed ician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):	
ificate be ex g physician as the burial	dicar	d	
box ba/ bu, death certificate be executed e attending physician and d for use as the burial-transit	Physician/med	IF FEMALE: 23b. Was decedent pregnant in the past 12 rgonths?  1 □ Vas 2 PM No 4 □ Pregnant at time of death 5 □ Other (specify)	23d. Date of delivery  Month Day Year
	nysi	9 Unknown 9 Unknown	
S, es the igner igner is de d	ò	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacc	co use contribute to the cause of death?  2  No 3 Probably 4 Unknown
as b 2 sl	ompleted	Peripharal Vasculor Disease 24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
/	ے د	Conjective Hunt failure	1? death?
90	0	25. Was case ferred to medical examiner?  1  Yes 2 No	
ding Physin. After this funeral di	- 16	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury 28b. Time of Injury 28b. Time of Injury 28c. Injury at Work? Work?	
r Atten r Atten ter deal irector; r by the	Ceruncation	3 Suicide 6 Could not be	t and Number or Rural Route Number, tate)
To the Hospitel of within 24 hours at To the Funerel D completely filled in	ealcal	29a. Certifier  (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and manner stated.	e(s) and manner as stated. and place, and due to the cause(s)
To the Hos within 24 h To the Fur completely	36	29b. Signature and title of certifier  29c. License number  29d. 1	Date signed (Month, Day, Year)
	-	30. Name and address of person who completed cause of death (Item 23a) Type, Print)  ERIC S. WID MALER M.D., 50 J BYRN St. Can	nlicider, MO-11-
State Registra	•	31. Date filed (MorNOV 'Dar) 7 2005 32 egistrar's Signature	01615

			For State Registrar	State of Maryla		artment of F rtificate of		Mental Hy	gien Reg. N	000	37713	
. *	T.		Decedent's Name (First, Middle, Last)			4.1	2. Date of De Month	eath	ay Year	3. Time of Death		
· ·	Physicia /Medic		Dayton			Klingma		Novemb	er (	3,2005		
+	Examin	er	4a. Facility Name (If not institution, give		4b. City, Town, o		ath		c. County of Dea			
	Funeral	# h	Shady Grove Adventily Social Security Number 6. S		s. last birthday)	Rockville If Under 1 Year   If Under 24 Hrs.   8. Date of 8				Montgomery  Birth Day, Year)  9. Birthplace (State or Foreign Country)		
**	Funeral Director		216-44-3060	5x M 2□ F 92	Yrs.	Months Days	Hours Min	Feb. 1	0, 1	913 Kans	ountry) Sas	
	Maryland f show	or	Usual Residence of Decedent  10a. State 10b. County	10c C	City, Town or Lo	ocation					10d. Inside City Limits	
136			1⊠Yes 2□No									
	r 28a-	Director	Maryland Montgome  10e. Street and Number	:I y	Galtne	10f. Zip Code			10g. C	itizen of What C	ountry?	
	be filed within 72 hours after death with the Maryland its Hygiene. Hygiene 44 Hygiene 64 defended other than "patural", or iteme 53a or 28a-f show or other than "patural", or iteme 23a or 28a-f show event. The Medical Examinar miner the patitive at	a D	407 Russell Avenú	ie #506		208	77		Uni	ted Stat	tes	
		by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☒ No	lispanic Origin? ( an, Mexican, Pue Specify:	? (Specify Yes or No- uerto Rican, etc.)  14. Race - American Indian, Black, White, etc.  Specify: White				
21215-0036	2 hours		15. Decedent's Ed	ducation	16a. Decedent's Usual Occupation				16b.	Kind of Business/Industry		
215	thin 7; e. e. Medi	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)			kind of work done DO NOT use retired	during most of w d)	rorking				
2	ygien ygien yerth f, fhe	Con		5+	Agro	nomist				eral Gov	vernment	
Maryland	m - 0 5	To Be	17. Father's Name (First, Middle, Last)					ame (First, Middle	e, Maide	n Sumame)		
Ž	should nd Me mark matic		Charles William K  19a. Informant's Name/Relationship (		19b. Mailir	ng Address (Street		Eichmann Rural Route Numb	er. City	or Town, State.	Zip Code)	
	nd 2 s lith ar 27 le r trau		00200	aughter)		Glen Ro						
ore,	of Head	1	20a. Method of Disposition	20b.		sition (Name of natory or other place		Date		Location - City or	Town, State	
altimore,	Page ment of uny or		1 ☐ Burial 2 ☒ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Tuennovan nom State	tropoli	tan Crem	atory 11		A1	exandria	a, Virginia	
Balt	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Itam 27 Is marked any injury or other traumatic as once.		21. Signature of Funeral Service Licen	isee //	1	Name and Addre	eer Park	c Drive	nera	1 Home		
	Physician /Medical Examiner		Gaithersburg, MD 20877  23a. Pag1. Egyler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate									
			shock, or heart failure. List only Immediate Cause (Final	one cause on each line.	atii. Do not siii	or the mode of dyn	ig, such as cardi	ac or respiratory t	arrest,		Interval Between Onset and Death	
			disease or condition resulting in death)	a. Sepsis  Due to (or as a conse	equence of):					· · · · · · · · · · · · · · · · · · ·	3 day	
				à				3 day				
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	equence of):								
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687		edical		d								
Records, P.O. Box	he death certificate be executed the attending physicien and ched for use as the burial-transit	Physiclan/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1								23d. Date of delivery Month Day Year	
	uires that the de	by Ph	Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?									
	The law require has been sage 2 shou										robably 4 Unknown	
		Completed	"					24a. Was auto perfe 1 \( \text{Yes}		death?	utopsy findings available completion of cause of 2 No	
	icien: certific ector,	Be	25. Was case referred to medicat examiner?  1. Types (All Description of Death (Check only one) (Check only one)									
	Phys r this ral dir	<u></u>	1 Tes 28UNO Vi Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify)									
	nding th. :: Alte e fune	atlor	27. Manner of Death 28a. Date of Injury 1 Deatural 5 Pending 2 Accident Investigation 28b. Time of Injury 28b. Time of Injury Work? 1 Yes 2 No 28b. Time of Injury Work?									
	To the Hospitel or Attanding Physicien: The law within 24 hours after death. To the Funeral Director: After this certificete has completely filled in by the funeral director, page 2.	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)									
		Medical (	29a. Certifier  (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	To the To the Comp	Ž	29b. Signature/and title of certifier	~ 01	4}	29c. Licens	e number			ate signed (Mont		
	10		110	Physrcs,	AN	pool	3088		Nove	ember 3,	700	
	1		30. Name and address of person who Mohit Ras tagi,	completed cause of death (Ite	9m 23a) (Type,	Print) Pedical	Center D:	بأنو				
The second second	Sta Registr		31. Date filed (Month, Day, Year)	32 Registrar's Sign	nalyte A	enti						
~	- V			40								

Unpend item#23a,27, per Me, g849,1123-05 Elnk. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Continue of Death AEM 05-07602 Lynda Marie Keeth For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Lynda Marie Keeth November 10. /Medical \_2005 4:00 P 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 10720 Georgia Ave. Montgomery Wheaton If Under 1 Year Months Days If Under 24 Hrs. 5. Social Security Number Age (In vrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖺 F Hours Min Director 220-94-4225 59 Jan. 21, 1946 New York Usual Residence of Decedent the Maryland **Work** 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene.
Department of Health and Mental Hygiene.
If them 21 is marked other than "naturel", or teme 23a or 28a-1 ehow any Injury or other traumatic event, if a Medical Evarinter must be notified at once. 1 ☐ Yes 2 No Maryland Montgomery Wheaton Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10720 Georgia Avenue, #105 20902 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Specify: White ģ 3 ☐ Widowed 4 Tx Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Never Worked N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Russell Nichols Elizabeth Bates 19a. Informant's Name/Relationship (Type, Print) - Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kimberly Michelle White 39796 Hearts Desire Lane, Mechanicsville, MD 20659 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State November 15 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crematory 2005 5 Other (Specify) Alexandria, Virginia 4 Donation 21. Signature of Funeral Service Licenses Francis Addess Corpins Funeral Home Inc 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Atherosclerotic Cardiovascular Disease /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) attending physicien and for use as the burial-transit certificate be executed Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Year 4 Pregnant at time of death 5 Other (specify) ed by the 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð ate has been sign page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of certificate has autopsy performed? death? 2 No 1 Yes 2□No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Scene Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☐ No this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending i within 24 hours after death.

To the Funeral Director: After Certification: Injury 5 Pending Natural 2 Accident 1 Tyes 2 No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifiei 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of/cert)field 29c. License number 29d. Date signed (Month, Day, Year) OCME November 11, 2005 30. Name and address of person who completed cause of death-(Item 23a) (Type, Print) Penn Street

DHMH 17 Rev 1/2001

State Registrar 111

NOV

Maryland 21201

Baltimore,

32. Pegistrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** November 3, 2005 ROBERT DOUGLAS KEGLEY, SR. 1:00 Ам /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year Sept. 23, 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) 1√2 M 2□ F Director 264-74-2114 60 Yrs. 1945 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Manyland nent of Health and Mental Hyglene. The file may be a marked other then "hatural", or iteme 23a or 28a-f show ant. If them 27 is marked other then "hatural", or iteme 23a or 28a-f show ury or other treumatic event, the Medical Examinant manual tremvilled at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo 1 ☐ Yes 2 No Maryland Frederick Frederick 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 10653 Stull Road 21703 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: Specify 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Heavy Equip. Operator R.F. Kline Inc. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James William Kegley Helen Josephine Faulker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Robert D. Kegley, Jr. (Son) 10653 Stull Road, Frederick, Maryland 21702 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Department of importent: if eny injury or once. Resthaven Mem. Gardens 11/7/2005 Frederick, Maryland <sup>¹</sup> 4 □ Donatio → 5 □ Other (Specify) 21. Signature of F 22. Name and Address of Facility & SON FUNERAL HOMES, 615 EAST MAIN ST., THURMONT, MD 21788 23a. Part 1. Enter the disease, or com-shock, or heart failure. List only o not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onsetland Death Immediate Cause (Final Priysician disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Physician/Medical Examiner Hospital or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death Month Day Year 5 Other (specify) P.0. the th 9 Unknown signed to Pan II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pan 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 NO 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 1 ☐ Yes 2 ☐ No 1 🗌 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification; To 1 Inpatient 2 XER/Outpatient 3 □ DOA this 28a. Date of Injury (Month, Day Yea) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) To the within 2 To the 29b. Signature and title of certifie 29d. Date signed (Month, Day Year) 0 29c. License number 18705 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alan L. Carroll, MD 310 South Seton Avenue, Emmitsburg, MD 21727 gistrar's Signature State 2005 Registrar

			1 - For State Registrar	State of	Marylan		artment tificate				lental Hy	giene	5 3	37716
	Dhusisi											ath Day	Year	3. Time of Death
	Physici /Medio		Marjorie Leona								November 4, 2005 11			11:00 PM
	Examir	ner	4a. Facility Name (If not institution,						Location of				ty of Death	
			Harford Memoria  5. Social Security Number		V. Age (In yrs.	(act hirthday)	If Under		de G		J			plana (State or Enroise
	Funeral Director		233-40-5670	1 ☐ M 2 💢 F	. Age (III yrs.	84 Yrs.	Months	Days	Hours	Min.	May 26	y, Year) 1921	Year) 9. Birthplace (State or Fore Country) Virginia	
Ш.			Usual Residence of Decedent								macy 20	, , , , , ,		
	filed within 72 hours after death with the Maryland Hygiene. ther than natural; or Itema 23a or 28a-f show int, tha Madical Examinar must be notified at	_	10a. State 10b. County 10c. City, Town or Location									1	0d. Inside City Limits 1 ☐ Yes 2 ☑ No	
		cto	Maryland Cecil Colora											
		吉	10e. Street and Number 10f. Zip Code 21917								10g. Citizen o	ISA	ntry?	
		erai	11. Marital Status	12. Was Dece	dent Ever in U	.S. 13. \	Was Decedent of Hispanic Origin? (Specify Yes or No- lf Yes, specify Cuban, Mexican, Puerto Rican, etc.)						ace - Americ	can Indian.
(0	r Iten	by Funeral Director	1 Never Married 2 Marrie	12. Was Deced Armed For d 1 ☐ Yes	ces? 2 📉 No					, Puèrto	Rican, etc.)	Ві	ack, White,	
03	ral', c	db	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Da	tes:		1□Yes 2	AJ No	Specify:			Spec	<sup>ify:</sup> Wh	ite
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121	perrait. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itema 23a or 28a-f show any injury or other traumatic svent, the Medical Examinar must be notified at once.	gin	Elementary/Secondary (0-12) College (1-4or 5+)  8 Homemaker								Ouna 4	Own Home		
d 2			17. Father's Name (First, Middle, La	est)		Homen	iuicet .	· · · · ·	18. Mothe	r's Name	(First, Middle,			
Maryland		To Be	Clarence E. Car	iter					Ida	Bel	le Creg	ger		
ary		-	19a. Informant's Name/Relationshi				-				al Route Numbe	-	n, State, Zip	Code)
			James Lawson/So	on		_					a, MD 2			
ore			20a. Method of Disposition 1   Burial 2 □ Cremation 3	B □Removal from S	tate 20b. F	Place of Dispo cemetery, cren	sition (Nam natory or otl	e of her place	9)	C	Date	20c. Location	- City or To	own, State
Baltimore,			'4 □Donation 5 □Other (Spe		Gr	andvieu	v Ceme	teri	y 1	1-10	-2005	Bluefi	eld,	Virginia
Bal			21. Signature of Funeral Service Li	f. Go	ropie						l Home, t, Risi		, MD 2	1911
	Physician and // // // // // // // // // // // // //		23a. Pan 1. Enter the disease, or complications in hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one could be not each line.										Approximate Interval Between Onset and Death	
			Immediate Cause (Final disease or condition resulting in death)									2	· days	
			Due to (or as a consequence of):									2 - 10 - 5		
,		ē	Sequentially list conditions, if any, leading to immediate	b. Due to (c	Due 10 for as a consequence of:								-	coay,
		Examiner	S uential y list conditions. if any, leading to immediate cause. Enter Underdying Cause (Disease or injury that inflated events											
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9 хо	ertifica ding pl	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy									204.0	22d Date of delivery	
Bo	leath certifica attending ph for use as ti	Physician/M	in the past 12 months?							23d. Date of delivery  Month Day Year				
o.	at the de by the a	hysi	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unkno										
٥,	signed signed d be de	by Pi								bbacco use contribute to the cause of death?				
ırd		ed t	Atrial Fibrilation 1 Yes  24a. Was an autopsy							es 2 Ano	s 2. □ No 3 □ Probably 4 □ Unknown			
ecords,	as been 2 shoul	Completed									24b. Were autopsy findings available prior to completion of cause of			
$\alpha$	Physician: this certifica al director, p		1 TYE								perfo	formed? death?		
Vital		9	25. Was case referred to medical examiner?	Hospital:				Otho			(Check only o			
of		- T									Home 5 ☐ Residence 6 ☐ Other (Specify)  28d. Describe how injury occurred			
	ding f h. After funer	tion								treet and Number or Rural Route Number,				
Division	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	ifica	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (5											
Ö		Certification;	4 ☐ Homicide building, etc. (Specify)  City or Town, State)											
	To the Hospital within 24 hours a To the Funeral completely filled	Medicai										ated. the cause(s)		
	To the withing To the comp	Ň	29b. Signature and title of certifier	300				License				29d. Date sign		Day, Year)
)			people!	Sell			\$	4000	2050	·		11/5	105	
	5	5   30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Prashant Shukla, MD 15 South Parke Street # 400 Aberdeen MD 2001												
	Sta Registr		31. Date filed (Month, Day, Year)  NOV 0 7 2005	Block 32. Re	gistrar's Signa	porte								

		,	1 - For State Registrar	State of M	Maryland /	•	artment of F tificate of				jiene <sub>eg. No.</sub>	5	3771	7
	Dhysioi	20	1. Decedent's Name (First, Midd							. Date of Dea Month		Year	3. Time of D	
	Physicia /Medic		Felisia Amis					· · · · · ·		et. 30,			5:50	РМ
	Examin	er	4a. Facility Name (If not institution				4b. City, Town, o	r Location o	of Death		4c. County	y of Death		
			Washington A		spital Age (In yrs. last	hirthday)	Takoma I If Under 1 Year		24 Hrs.   a	Date of Birth	Montg		7 place (State or I	Foreign
	Funeral Director		None	1 □ M 2 🗓 F	68	Yrs.	Months Days	Hours	Min.	Month, Day	Year) 1937	Ker	ntry) 1Va	Greigh
			Usual Residence of Decedent											
	ylanc how		10a. State 10b. Count	у	10c. City, To	own or Lo	cation						10d. Inside City	
	e Ma	ctor	Maryland Mont	gomery	Silve	r Sp	ring						1X∑Yes 2	2   No
	ith th	Oire	10e. Street and Number				10f. Zip Code			1	log. Citizen of	What Cou	ntry?	
	ath w	rai	1517 Dilston R				20903				Kenya		and to the c	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other treumetic svent, the M-dical Examiner must be notified at once.	by Funeral Director	11. Marital Status  1 □ Never Married 2 Ma  3 □ Widowed 4 □ Divorce	If Yes, Give	s? KINo		Vas Decedent of H f Yes, specify Cuba I □ Yes 25 No	lispanic Ori an, Mexicar Specify:		ty Yes or No- can, etc.)	Bla	ce - Amenick, White, $y_i = B1$		
2-0	72 ho	ted	15. Decede	nt's Education est grade completed)	1	6a. Deced	lent's Usual Occup	ation	st of working		16b. Kind of B	lusiness/lr	ndustry	
2	ithin .	Completed	Elementary/Secondary (0-12)	College (1-4d	or 5+)		kind of work done DO NOT use retired	d)			371			
7	ed w ygier ygier yer th	Cor		2		MILII	ister	40.00		5	Mini			
ğ	be fill htal H bd otl	Be	17. Father's Name (First, Middle David Mukabi	, Last)					ers Name (/ roba I		Maiden Sumar	me)		
1	nould I Mer narke	To	19a, Informant's Name/Relation	ohio (Tima Brint)		Ob Mailie	ng Address (Street				r City or Tour	State Zie	n Codol	
Maryland	d 2 sl th an 7 ls r treur	W i	William T. Muk				Dilston 1							
	1 an Heel Heel Sem 2		20a. Method of Disposition	abane (5011)	20b. Place	of Dispo	sition (Name of	- 1	Dat		20c. Location			
5	ages ont of		1 Burial 2 Cremation 4 Donation 5 Other		118   .		natory`or other plac Village		11/14/	05	Nairob	i. Ke	nva	
Baltimore,	permit. Pages 1 and 2 should be filed within Department of Heelth and Mental Hygiene. Importent: If Item 27 Is marked other than any injury or other treumetic svent, the Monte.		21. Signature of Funeral Service				. Name and Addre							
Ä	Ded Imp		Indre'	Thomason	~	+	7400 Geo	rgia .	Ave. N	N.W., W	ashing	ton,	D.C. 2	20012
	Physician /Medical Examiner	16	23a. Part1. Enter the disease, is shock, or heart failure. Lis immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions.	a. Sepsi Due to (or Esop)	h line.	ce of): Cance		ng, such as	cardiac or r	espiratory arr	est,		Approximate Interval Betwe Onset and De	
68760,	ficate be executed physicien and is the burial-transit	edicai Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Gastr	rointest as a consequen	ina1	Bleed							
P.O. Box 6	deeth certi e attending id for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		n 2 ☐ Fetal death t at time of death	ath 3□	Ectopic pregnanc Other (specify)	/				ate of deliv	ery Day Ye	ar
	quires that n signed I	by	Part II. Other significant condi	tions contributing to deat	h but not resultin	g in the u	nderlying cause giv	en in Part I	l.				the cause of dea bably 4 ∐Uni	
Records,	The law requires that the sate has been signed by the page 2 should be detache	Completed								24a. Was a autops perform	sy med?	prior to co death?	opsy findings av empletion of cau	railable ise of
Vital	Physician: The this certificate ral director, pag	Bec	25. Was case referred to medic examiner?						e of Death (	Check only or				
of V	ding Physician: The After this certific funeral director.	은	1 ☐ Yes 2 XNo	Hospital:		Outpatier		4 🗀 140			ence 6 🗆 Oth		fy)	
		Certification;	27. Manner of Death 1 □ Natural 5 □ Pend	iiig	njury 28 <i>Day Year)</i>	b. Time of Injury	Wo			d. Describe h	ow injury occur	rred		
Division	Attending in death.	cat	2 Accident inves 3 Suicide 6 Could	tigation	Inium. At homo	fo.—		Yes 2		f Location /S	treet and Numi	hor or Pur	al Route Numbe	9.5
Σ	or A after Direct in by	artif	4 Homicide deter	mined 286. Flace of building,	etc. (Specify)	, iaiii, su	eet, factory, office		20	City or Town		Der Grinari	ar i lodio riumbo	,,
_	To the Hospital or Attent within 24 hours effer death To the Funeral Director: completely filled in by the	Medical Co		ing Physicien: To the be all Exeminer: On the basis and manner	s of examination		vestigation, in my o	pinion, dea		at the time, d	late and place,	and due t	o the cause(s)	
	Vith To 1	Σ	29b. Signature and title of certif				29c. Licens		2		29d. Date signe		Uay, Year)	
,	4		/ Jen 1	represe s	Doero	R		370		(	0/31/	v )		
_	1		30. Name and address of person	4 UPR			TALL		BAR		0-20	0912	2	
	Sta Registi		31. Date filed (Month, Day, Yea NOV 0 4	7) 32. Regi	istrar's Signature	Apo	de							

29d. Date signed (Month, Day, Year)

102/2005

**Physician** /Medical Examiner **Funeral** 

Director

death with the Maryland

filed within 72 hours after

Baltimore, Maryland 21215-0036

rthan "natural", or Items 23a or 28a-f sho the Medical Examiner must be notified at Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Int: If Item 27 Is marked other than 1 other traumatic event.

Physician /Medical **Examiner** 

= 5 permit. Page Department ( Important: If

injury

burial-transit The law requires that the death certificate be executed and the attending physician as the use ō signed by the al should t director, page 2 certificate this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral of Hospital or Attending the the

Division of Vital Records, P.O. Box 68760,

Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 3:20 P M 30, 2005 October Mary Crowley Mitchell 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Silver Spring Woodside Center If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
Nov. 26, 19 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Months 1 □ M 250 F 92 1912 New Jersey 578-28-5659 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 1 Yes 2 □ No Silver Spring Maryland Montgomery Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20910 9510 Hale Place United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 TNo Specify: Specify: Black Ď 3 XWidowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade comp (Give kind of work done during most of working life. DO NOT use retired) completed) Elementary/Secondary (0-12) College (1-4or 5+) Social Worker D.C. Government 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Samuel Crowley Anne (maiden name unknown) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Joseph W. Sudduth (friend) 9510 Hale Place, Silver Spring, MD 20910 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Lincoln Memorial Cem. 11/5/05 Suitland, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility McGuire Funeral Service 21. Signature of Funeral Service Licensee 20012 ndre Shompson 7400 Georgia Avenue, N.W. Washington, D.C. 23a. Part 1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Immediate Cardio Pulmonary Arrest disease or condition resulting in death) Due to (or as a consequence of): 20 + yrs. Chronic Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) 20 + yrs. Generalized Arteriosclerosis that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death Year Month Day in the past 12 months? 5 Other (specify) ☐Yes 2☑No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 ☐ Probably 4 ☐ Unknown Peripheral artrial Insufficiency with gangrene foot 1 ☐ Yes X☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Wasan Multi Infarct Dementia autopsy performed? 1∐ Yes 22Ū No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 🕅 Nursing Home 5 🗌 Residence 6 🗀 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 1 ☐ Yes 2 🔼 No 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 5 Pending investigation 12CXNatural 1 ☐Yes 2 ☐ No М 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

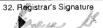
State Registrar

31. Date filed (Month, Day, Year) NOV 04

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(Check only one)

29b. Signature and title of certified



MAD

Betten,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



29c. License number

MD 25586

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			For State Registrar	State	of Marylar			nt of H				giene Reg. No.	105	3	7719	
		×2	Decedent's Name (First, Middle	e, Last)		-					2. Date of De	ath			3. Time of Death	
	Physicia		Tames	P Mc	Neil						Month	ben \	3-00		MA 5650	
9	/Medic Examin	- 8	4a. Facility Name (If not institution	n, give street and	number)		4b. Cit	y, Town, or	Location of	of Death		4c. (	County of De			_
	1 64		Shady Grove Ad	ventist	Hospital		Ro	ckvil	le				Montg	omer	у	
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.		If Und	er 1 Year s Days	If Under	24 Hrs. Min.	8. Date of Bir (Month, Da	th v. Year)	9. B	irthplac	e (State or Foreign	Ī
100	Director		127-24-7144	<b>№</b> М 2 П Р	72	Yrs.					April 9		33 N	ew Y	ork	_
	pu *		Usual Residence of Decedent  10a. State 10b. County	,	10c. Ci	ty, Town or Lo	cation							10d.	. Inside City Limits	-
	anyla hov	5		gomery		ermant									1 ☐ Yes 2 ☑ No	
	28a-f	Directo	Maryland Mont  10e. Street and Number	gomery		CIMAIIC		ip Code				10a Citiz	en of What	Country	?	-
	with a or	ä	21000 Father	Hurlev B	lvd. Apt	. 202	10.1.2	208	74					USA		
	eath	Funerai	11. Marital Status		ecedent Ever in L		Was Dec			gin? (Spe	cify Yes or No	)- 1	4. Race - An	nerican	Indian,	-
<b>'</b> 0	r iter	듄	1 Never Married 2 Mar	ried Mi∏Ye	Forces?		If Yes, sp	ecify Cuba	ın, Mexican	i, Puerto I	Rican, etc.)		Black, Wh			
8	of, o	Ď	3 XWidowed 4 ☐ Divorced	If Yes, Year o	Give r Dates: Unkn	own	1 L Yes	<b>2</b> € No	Specify:				Specify: W]	hite	9	
2	be filed within 72 hours after death with the Maryland ital Hygiene. Id other then "naturel", or iteme 23a or 28a-f ehow ovent, the Medical Examiner must be notified at	Completed	15. Deceder (Specify only highe	nt's Education	ad)	16a. Dece	dent's Us	sual Occupa	ation during mos	t of workii	าล	16b. Kin	d of Busines	ss/Indus	stry	
2	ithin le.	nple	Elementary/Secondary (0-12)	College	e (1-4or 5+)				during mosi I)		3		2 2			
7	ed w ygier her th	S			+	Ma	nage	ment	40 14-45-	d. None	(First, Middle			GOV	vernment	_
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "naturel", or Iteme 23a or 28a-f ehow any injury of other traumatic event, the Medical Examiner must be notified at one.	Be	17. Father's Name (First, Middle, James McN								Docher		oumame)			
3	d Mer narke	ို				10h Mailie	o Addra	an /Street			I Route Numb		Tour State	Zin Co	nda)	_
Mai	12 st h and 7 is n		19a. Informant's Name/Relations Martin J. McN		n		~				Germa					
e,	Healt The The	}	20a. Method of Disposition		20b.	Place of Dispo	sition (A	ame of			ate		ation - City o			-
ō	nt of nt of		1   Burial 2 ☐ Cremation			cemetery, crea te of He					per 5,					
를	urtme vrtani vrtani njury		4 ☐ Donation 5 ☐ Other (S			22	2_Name	and Addres	ss of Eacilit	200					, Marylan	K
Ba	Deprime timpo		Kon Still	2			Fran 500	cıs J Unive	rsity	Tins Blv	Funera d, W,	aı но Silve	me ind r Spr	c. ing,	MD 20901	L
	* "		23a. Part. Enter the disease, o	r complications the	at caused the dea									A	pproximate	-
	Dhysisian		shock, or heart failure. List Immediate Cause (Final	only one cause o		mi	(35 -			5 ~ 5	ecases and	0.0		0	iterval Between nset and Death	
	Physician /Medical		disease or condition resulting in death)	a. Due	to (or as a consec		000	we!	<u>~  </u>	(, ( ,	sarc H	010		1	11 (110013)	-
	Examiner				iabet	es m	11.31	: tus								
dr.	A 7,584	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due Due	to (or as a consec	quence of):										
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Ó,	e exe ien a	EX	resulting in death) Last	Due	to (or as a consec	quence of):										
8760,	The law requires that the death certificate be executed ate has been signed by the ettending physicien and page 2 should be detached for use es the burial-transit	dical		d										-		-
9	entific ling p	Med	IF FEMALE:	02- 14												7
Вох	eath certific ettending p for use es	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 Liv	outcome of pregn re birth 2 Tet	al death 3[		pregnancy				2	3d. Date of d Month	lelivery Da	ay Year	
P.0.	the d	ysic	1 ☐ Yes 2 ☑No 9 ☐ Unknown		egnant at time of one nknown	Jean 5	Other (	specify)								
۵.	that the dened by the ended the	Ph	Part II. Other significant conditi	ons contributing to	o death but not re	sulting in the u	nderlying	g cause give	en in Part I.		23e. Did t	obacco us	e contribute	to the	cause of death?	
Division of Vital Records,	uires tha signed Id be del	d by									1 🗆	Yes 2	]No 3 []	Probab	ly 4 kinknown	
202	w requir been sl should I	lete									24a. Was	an	24b. Were	autopsy	findings available	-
Be	he lav e has	Completed										rmed?	prior to death	o comp	letion of cause of	
la	ificat or, pa	Ö	25. Was case referred to medica	ıl					26 Place	of Death	1 ☐ Yes (Check only o	2 <b>3</b> 2No	1 □ Ye	es 2	<u>≤</u> No	-
>	Physicien: r this certifica ral director, p	ToB	examiner? 1 ☐ Yes 2 2 No	Hospital:	☐ Inpatient 2 🖟	ER/Outpatier	nt 3 🗆 1	Oth	or		ne 5 Resi		Other (St	pecify)		
0	g Phy er thi		27. Manner of Death	/1	ate of Injury fonth, Day Year)	28b. Time o		28c. Injun World	y at	2	28d. Describe	how injury	occurred			-
jor	Mtendin death. ctor: Aft y the fur	atio	Z LI Accident	igation	ionii, buy rour,	1.1,0.1	М		Yes 2	No						
ĭ	f or Atte after de Directo	Certification:	3 Suicide 6 Could 4 Homicide determ	nined 289. Pi	ace of Injury - At hilding, etc. (Speci	nome, farm, sti	reet, fact	ory, office		2	28f. Location (. City or To			Rural R	oute Number,	
	itato rsaft ral Di															_
	To the Hospital or Attending Physicien: The within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medicai	(Check only 2 Medical	ng Physician: To Examiner: On the	e basis of examin											
	thin 2 the the mplei	Med	one) 29b. Signature and title of certific		nanner stated.			9c. License	e number			29d. Date	signed (Mo.	nth, Da	y, Year)	-
!	# 3 # 8 #	0	M10:1X	huse	2		ļ	02:	0-1	G		<u> </u>				
	3		30. Name and address of person	who completed c	ause of death (Ite	m 23a) (Tyne	Print)	W 31				, 4	eue no	un	1,2005 le mo	-
	(1)		Debivah J	. /~		9901	m	edir	al C	en:	tern	C 8	ock	VIV	le mo	
	Sta	te	31. Date filed (Month, Day, Year	) 32	2. Registrar's Sign	ature	frank	20		- 1					20850	1
Ġ	Registr	ar	NOV 0	4 2005	Partie 18	ST A										-

		K		partment of Health and Mental Hygiene 05 37720
			1. Decedent's Name (First, Middle, Last)	2. Date of Death  Month  Day  Year  3. Time of Death
	Physicia /Medic		Lennis Eva Mahoney	November 6, 2005 8:10 P <sup>M</sup>
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death  4c. County of Death
			Citizens Nursing Home	Frederick Frederick
	Funeral Director		5. Social Security Number  578-30-3908  6. Sex 1 □ M 2 ▼ F  7. Age (In yrs. last birther Yr)  78	Months Days Hours Min. (Month, Day, Year) Country
	and	-	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town of	r Location 10d. Inside City Limits
	Maryl f sho	ō	Maryland Frederick Adams	1 ☐ Yes 2 ☑ No
	the	Director	10e. Street and Number	10f. Zip Code 10g. Citizen of What Country?
	h with	a D	3429 Tudor Drive	21710 United States
9	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Heelth and Mental Hyglene. Important: If Itam 27 is marked other than *natural', or Items 23a or 28a-f show any injury or other traumatic event, the Marileal Examinational page.	by Funerai	11. Marital Status  1 □ Never Married 2 □ Married  1 □ Ves 2 ☑ No If Yes, Give	3. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 □ Yes 2录 No Specify: Specify: White
003	ural',	d b	3XXWidowed 4 Divorced Year or Dates:	
15-	in 72 t	Completed	(Specify only highest grade completed) ((	acedent's Usual Occupation 16b. Kind of Business/Industry live kind of work done during most of working e. DO NOT use retired)
212	d with giene ar tha	mo:	12	Manicurist Cosmetology
멀	al Hy I oth	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Sumame)
yla	ould to Ment	၉	Wilford Mallette	Marguerite Slaughter
Mar	nd 2 sh eith and 27 ie m r traum			ailing Address (Street and Number or Aural Route Number, City or Town, State, Zip Code)  9 Tudor Dr., Adamstown, MD 21710
Baltimore, Maryland 21215-0036	ages 1 a int of Hee t: If Itam y or othe		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	sposition (Name of crematory or other place)  November 9,
Itin	nit. P vartme ortan Injury	1	21. Signature of Ineral State Librasee	n Mem. Gardens 2005 Frederick, Maryland 22. Name and Address of Facility Resthaven Funeral Services, Skkot Cody P.A.
Ã	Departing Department on the procession of the pr	4	1200	9501 Catoctin Mtn. Hwy. Frederick, MD 21701
	-		23a. Part Enter the disease, or complications that caused the death. Do no shock, of rear failure. List only one cause on each line.	enter the mode of dying, such as cardiac or respiratory arrest,  Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	ung Corneer Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequence of	
		e.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated eyents	
o,	ate be executed hysician and the burial-transit		resulting in death) Last Due to (or as a consequence of	
8760,	cate be executed physician and the burial-transit	dicai	d	
Box 6	death certifics e attending pt ed for use as t	n/Me	IF FEMALE: 23b. Was decedent pregnant 1□Live birth 2□Fetal death	3 Ectopic pregnancy
O. B		Physician/Me	in the past 12 months?  1 ☐ Yes 2 ☐ No 9 ☐ Unknown	5 Other (specify) Month Day Year
S, P	requires that the een signed by th hould be detache	by Pt	Part II. Other significant conditions contributing to death but not resulting in t	
ord	w require been sig should b			1  Yes 2 No 3 Probably 4 Unknown
of Vital Record	elaw hasb	ompleted		24a. Was an autopsy autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No 1 □ Yes 2 □ No
ita	ician: Th certificate rector, pag	BeC	25. Was case referred to medical examiner?	26. Place of Death (Check only one)
) t	d is	2	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outp	
	fter	ion:	27. Manner of Death  1 Natural 5 ☐ Pending  28a. Date of Injury (Month, Day Year)  Inj	
isic	Attending ir death. ector: After by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farr	
Division	ial or Attendii s after death. al Director: A ed in by the fu	Certification:	4 Homicide determined building, etc. (Specify)	City or Town, State)
	10 5 to 1	Medical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, (Check only one)  2 Medical Examiner: On the basis of examination and and manner stated.	leath occurred at the time, date and place, and due to the cause(s) and manner as stated. or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
	To the Hosl within 24 ho To the Func completely f	Me	29b. Signature and title of certifier	29c. License number 29d. Date signed (Month, Day, Year)
)			1 Souly mo M.	D D 58391 11-07-05
_	7		30. Name and address of who completed cause of death (Item 23a) (TSAJJAD A212, MD 801	
	Sta Registi		31. Date filed (Month, Day, Year)  NOV 0 9 2005  32. Restrar's Signature	Sparle

State of Maryland / Department of Health and Mental Hygiene 15 1 - State Registrar Certificate of Death Reg. No 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month
Nov.06, 30c 4c. County of Death 110 AM Physician Robert McDonald Masser Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Co. Hospital Washington Hagerstown 8. Date of Birth (Month, Day, Year Oct. 20, If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex Social Security Number Year) **Funeral** Months 1921 517-30-7656 84 MD Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland 10a State 10b County 7 is marked other than "natural", or items 23a or 28a-1 show traumatic event, the Machea Examinar must be notified at 1XXX es 2 ☐ No Washington Boonsboro Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 29 S. Main St. 21713 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ②ONo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 XNo Specify: Baltimore, Maryland 21215-0036 Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) service station operator petroleum

18. Mother's Name (First, Middle, Maiden Sumame) 12 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Itam 27 is marked oth any linjury or other traumatic event ODE. Be ( George W. Masser Jennie McDonald 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Hazel masser (Wife) 29 S. Main St., Boonsboro, MD 21713 20a. Method of Disposition 20b. Place of Disposition (Name or Metable ry XSurial 2 ☐ Cremation 3 ☐ Removal from State 11/9/05 Jefferson, MD Jefferson United 4 Donation 5 Other (Specify) DonaTadd B. Thompson Funeral Home 31 E. Main St., Middletown, MD 21. Signature of Funeral Service Ligensee Se Rant. For the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Vancular Accident with Left herripercuis consequence of:
8bs huctive Pulmary disease
consequence of:
two Heart Failure Immediate Cause (Final disease or condition resulting in death) Ceuchro **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of):

Ongctwo H Examiner The law requires that the death certificate be executed use as the burial-transit and that initiated events resulting in death) Last Due to for as a consequence of) Division of Vital Records, P.O. Box 68760, physicien by Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy signed by the atten d be detached for u Month Day in the past 12 months?
1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Onknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed has 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 00 After this certification funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2000 ို 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident the 28f. Location (Street and Number or Rural Route Number, City or Town, State) Director 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Thomicide To the Hospital o within 24 hours aft To the Funeral Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 20062223 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 340-MILL STREET HAGELSTENEN MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

NOV 0 9 2005

		Please 1  1 - For State Registrer			/ Depa		Health and	All Copies All Mental Hyg	9	i 37722
Physicia /Medica Examine	al .	Decedent's Name (First, Middle, Last,     Ethel  4a. Facility Name (If not institution, give)	Grace	Mes	sner	4b. City, Town, o	or Location of De	2. Date of Deat Month	Day \	3. Time of Death OO5 7 A M Death
Funeral Director		St. Catherine's Nu 5. Social Security Number 219–20–3038 6. Security Number 10		nter e (In yrs. lasi 82	t birthday) Yrs.	Emmitsb If Under 1 Year Months Days	If Under 24 H		Frede	rick B. Birthplace (State or Foreign Country) Maryland
72 hours after death with the Maryland natural", or Items 23s or 28s-f show deat Evaninal the restlined at	ector	10a. State 10b. County  Maryland Frederick  10e. Street and Number	τ		rmont	ation		1	0g. Citizen of Wh	10d. Inside City Limits 1 □ Yes 2 🛣 No
s 23a or	Funeral Director	15709 Smith Road			142.11	217			USA	
72 hours after death with the Maryla 72 hours after death with the Maryla 7atural; or Items 23a or 28a-f shot dical Examinal most be notified at	þ	1 <b>X</b> Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	No .	1	□Yes 2√x No	Specify:	(Specify Yes or No- erto Rican, etc.)	Black,	American Indian, White, etc. White
	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e completed) College (1-4or 5		life. L	ent's Usual Occuj kind of work done OO NOT use retire undry Wo	d)	vorking	16b. Kind of Busi	·
a of fill	To Be Co	17. Father's Name (First, Middle, Last)  Melvin Evers	: Me	essner		undry wo	,	lame (First, Middle, M		
t and 2 shoust the and N tem 27 is main other treumain		19a. Informant's Name/Relationship (T) Doris Rippeon/Niec			12403	Detour	Road,	Rural Route Number,  Keymar, MD	21757	
		20a. Method of Disposition  Burial 2 Cremation 3 F  ' 4 Donation 5 Other (Specify)				sition (Name of satory or other pla				ity or Town, State  MD 21702
permit. Page Department of Importent: If any njury or once.		21. Signatore of Funeral Service Licens	0					tauffer Fu et, Thurmo		
E icia B	icai Examiner	23a. Part. In the diseast or complete sock or heart failure. List may of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as  Due to (or as  Due to (or as  Due to (or as	a consequer  The a onsequer	out nce of): GE nce of):	a		OID D		Approximate Interval Between Onset and Death 7 DA7S C G Month 1 4 FEhr
The law requires that the death certificate is the has been signed by the attending physicage 2 should be detached for use as the the table.	Physiclan/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 25 No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal de	eath 3	Ectopic pregnand Other (specify)	у		23d. Date Month	
w requires that the de been signed by the a should be detached f	þ	Part II. Other significent conditions co	ntributing to death b	ut not resultii	ng in the un	derlying cause gi	ven in Part I.	23e. Did tob		ute to the cause of death?
sicien: The law requ	Completed								prid? dea	ere autopsy findings available or to completion of cause of ath?  Yes 2 \sum No
hysicier his certif	To Be	25. Was case referred to medical examiner?  1 □ Yes 2 □ No	Hospital: 1  Inpatie	ent 2□EF	VOutpatien	3 DOM	ner: Nursing	eath (Check only on Home 5 Reside		(Specify)
To the Hospital or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification:	27. Manner of Death  10 Natural 5   Pending 2   Accident investigation 3   Suicide 4   Homicide determined	28a. Date of Inju (Month, Da 28e. Place of Inj building, et	y Year) ury - At home	Bb. Time of Injury e, farm, stre	28c. Inju Wo M 1 eet, factory, office	ryat rk? ]Yes 2 □ No	28d. Describe ho	reet and Number	or Rural Route Number,
To the Hospital or Attendiwithin 24 hours after death. To the Funerel Director: A completely filled in by the fu	edicai Cer	29a. Certifier 1 Certifying Phy (Check only one) 2 Medicel Exemi	sicien: To the best	of my knowle	edge, death	occurred at the ti	me, date and pla opinion, death or	ice, and due to the ca	use(s) and mannate and place, and	ner as stated. d due to the cause(s)
To the within 7 To the comple	Med	29b. Signature and title of certifier	REMPE	-C-R	PRIK	To Sec. Licen	se number	25 7 1	9d. Date signed (	Month, Day, Year)
8		30. Name and address of person who co	REMPE	L-Pa	RII	Print) ERDO	520 THU	EUN DER	STRE	21788
Sta Registr		31. Date filed (Month, Day, Year) NOV 0 9 2	32. Figistr	ar's Signatur	& A	nerle				- 50

				epartment of Health and M Certificate of Death		gie <b>2</b> e0 0 5	37723
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) Emmett Harold Murphey		2. Date of Dea Month October		3. Time of Death 5 9:58P M
	Examin		4a. Facility Name (If not institution, give street and number) 42 S. Springdale Rd.	4b. City, Town, or Location of Death Westminster		4c. County of Death	
	Funeral Director		717 12 1701	day) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day Oct. 2,	9. Birth	nplace (State or Foreign untry) I NO I S
	Maryland I-f show	tor	Usual Residence of Decedent           10a. State         10b. County         10c. City, Town           Maryland         Carroll	or Location Westminster			10d. Inside City Limits 1 ☐ Yes 2X☐ No
	n with the 3s or 28s	al Director	10e. Street and Number 42 S. Springdale Rd.	10f. Zip Code 21158	1	Og. Citizen of What Co.	untry?
920	be filed within 72 hours after death with the Maryland ital Hyglene. d other then "naturel", or Items 23a or 28a-f show event, the Medical Examinating mast be indifficed at	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Spill Yes, specify Cuban, Mexican, Pueno 1 ☐ Yes 2 ⚠ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amel Black, White Specify: Wh	
Baltimore, Maryland 21215-0036	d within 72 ho glene. Ir then "natur Ir e Medical.	Completed	(Specify only highest grade completed)	Decedent's Usual Occupation Give kind of work done during most of work life. DO NOT use retired) machinist		16b. Kind of Business/I canning equ manufactu	ipment/
land	2 should be filed and Mental Hygli is marked other reumetic event, II	To Be C	17. Father's Name ( <i>First, Middle, Last</i> )  Ovid Warner Murphey	18. Mother's Name Nelli		Maiden Sumame) Charlton	
Mary	as 1 and 2 should of Health and Men fitem 27 is marke r other treumetic		5	Mailing Address (Street and Number or Run S. Springdale Rd.		r, <i>City or Town, State, Z</i> nster, MD 2	
imore	Pages nent of ant: If i		1 🛪 Burial 2 🗆 Cremation 3 🗆 Removal from State	, crematory or other place) ul's Luth. Cem. 11/1/	/2005	20c. Location - City or T Uniontown	, MD
Balt	permit. Departr Imports any Inju		21. Six ay re of Fineral Service Licensee	22. Name and Address of Facility Har 310 Church St. Ne	tzler F w Winds	uneral Home or, MD 2177	6
f	Physician //Medical Examiner  the printing t	i Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list condition if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of cause (Disease or injury that initiated events resulting in death) Last	wen exporasis	or respiratory arm	est,	Approximate Interval Between Onset and Death
O. Box 68760,	The law requires that the death certificate be execuled the been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	d.  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9  Unknown  d.  23c. If yes, outcome of pregnancy 1  Live birth 2  Fetal death 4  Pregnant at time of death 9  Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of deliver Month	very Day Year
rds, P.	w requires that been signed should be det	by	Part II Other significant conditions contributing to death but not resulting in Dr. Sec.			bacco use contribute to es 2 □ No 3 □ Pro	the cause of death?
al Records,		Completed				sy 🖊 prior to c	opsy findings available ompletion of cause of
Division of Vital	Attending Physicien: 1 death. ctor: After this certifica y the funeral director, p	Certification; To Be	2 Accident investigation 3 Suicide 6 Could not be	me of ury 28c. Injury at Work?  M 1 Yes 2 No	me 5 eside 28d. Describe ho	e)  once 6 Other (Spec ow injury occurred  reet and Number or Ru	
Div	pitel or Attend burs after death eral Director: , filled in by the f		29a. Certifier  3 Suicide  determined  determined  28e. Place of Injury - At home, fan building, etc. (Specify)		City or Towr	n, State)	
	To the Hospitel or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and and manner stated.  29b. Signature and title of pertitier	or investigation, in my opinion, death occurr	ed at the time, d	ate and place, and due	to the cause(s)
	WIL 3		30/Name and address/ person who completed cause of death (Item 23a) (1	(ype. Print)		(0)31/05	-
	Sta		31. Date filed (Month, Day, Year)  NOV 0 2 2005	e Street Westmin	Ster, Mi	321151	
	Registr	ar	NOV 0 2 2005 Steven &	Grade 3			

				State of Ma	ryland / Dep						Jibie.	
			1 - For State Registrar		- '	rtificat				Reg Roll	15	37724
	<sup>™</sup> Physici	an.	1. Decedent's Name (First, Middle, Last,	)	· · · · · · · · · · · · · · · · · · ·		•		2. Date of D	eath Day	Year	3. Time of Death
	/Medic		ETHEL MAY OAKLE						NOVEME	BER 2, 2	2005	6:45 A M
	Examir	ier	4a. Facility Name (If not institution, give			4b. City,	Town, or	r Location of Death			nty of Death	
	Eupovol		MILLENNIUM HEALTH  5. Social Security Number 6. Sec		ITATION (In yrs. last birthday		EWAT 1 Year		8. Date of B	irth	ARUN 9. Birth	
	Funeral Director			M 2□ <b>X</b> F	94 Yrs.	Months	Days	Hours Min.	MAY 1	ay, Year)		nplace (State or Foreign untry) YLAND
	pu ,		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L							
	Aarytan f show ed at	ō										10d. Inside City Limits 1 √2 Yes 2 □ No
	28a-1	Director	MARYLAND ANNE ARUN 10e. Street and Number	NDE'L	ANNAPOLIS	10f. Zip	Code			10g. Citizen o	of What Cor	
	h with	al Di	15a elliott road			214	103			UNITED		
	ams ams	Funeral		12. Was Decedent E Armed Forces?	ver in U.S. 13.			ispanic Origin? (Si an, Mexican, Puert	pecify Yes or N	o- 14. R		ican Indian,
36	s afte		1 Never Married 2 Married	1 ∐ Yes 2 X No If Yes, Give		1 ☐ Yes		Specify:	, , , ,		cify: WHI	
21215-0036	within 72 hours after death with the Maryland ena. than "natural", or Itams 23e or 28e-f show fra Madical Examinar must be notified at	Completed by	3 XWidowed 4 ☐ Divorced  15. Decedent's Edu	Year or Dates:	16a Dece	edent's Usua		ation		16b. Kind of		
215	ın 72 ın "nı Madik	plet	(Specify only highest grade Elementary/Secondary (0-12)	e completed) College (1-4or 5+	(Give	e kind of wor DO NOT us	rk done d	durina most of wor	king	100. Killa or	Du3111633/11	industry
21	filed with Hygiens Sthar the ant, the	Com	12	0		MAKER				HOME		
Ind	be file	Be	17. Father's Name (First, Middle, Last)					18. Mother's Nam	e (First, Middle	e, Maiden Suma	ame)	
Maryland	should be filed within 72 hours after death with the M nd Mental Hyglena. s markad other than "natural", or Itams 23a or 28a-f umatic event, I're Medical Examinar must be nutifit	T <sub>0</sub>	DAVID W. COLLISON  19a. Informant's Name/Relationship (Ty	una Print)	10h Mail	ling Addross	/Ctrant	ELLEN LO			C4-4- 7	i- C- t-)
Ma	2 pa as as				40400			and Number or Ru	CLEVE LE CRETCHE CO	0000 0 amango	210	ip Code)
5	s t and s t Health itam 27 othar tra	1	20a. Method of Disposition	(SISTER)	20b. Place of Disp	cosition (Nan	ne of	1	Date	1D. 2140 20c. Location	7.00	Town, State
E	Pages lant of int: If it		1 ☐ Burial 2 X Cremation 3 ☐ P  `4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	KALAS CR			11-03	3-05	EDGEWA	TER M	D.
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr once.		21. Signature of Fd all Section Liouns		2	22. Name an	d Addres	ss of Facility GEX	ORGE P.	KALAS F	UNERA	L HOME
	E # E D	1 9	160.	0/2				ONS ISLA			ATER,	
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final	ne cause on each line	ne death. Do not er	iter the mod	e ot dyin	g, such as cardiac	or respiratory a	arrest,		Approximate Interval Between Onset and Death
A	Physician /Medical		disease or condition resulting in death)	- Carclic	consequence of):	2 hy	-th	m)'0:				5 minules
	Examiner		1200 - 10	Athon	consequence of):	H'C	Car	diova	veilan	dise	050	
	n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		consequence of):	11-	COCF					
	e ba executad /sician and e burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (ex ex e								
760,	ba ex ician burial	cal E			consequence of):							
687	<u> </u>			t.								
Вох	n certi anding use a	n/M	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome o		П <b>С</b> -1				23d. C	ate of deliv	very
	ed for	sicia	in the past 12 months? 1 ☐ Yes 2 ☑ No	4□Pregnant at ti		□Ectopic pro □ Other (sp				٨	Aonth	Day Year
P.0	d by the	Phy	9 ☐ Unknown  Part II. Other significant conditions cor		not requiting in the	undark inn		-a ia Dani	220 Did	tahaasa waa sa	na de la composición de la composición de la composición de la composición de la composición de la composición	the cause of death?
ds,	The law raquires that the death certifica ate has been signad by the attending ph page 2 should be detached for use as th	Completed by Physician/Med	Decubitus 11	_	Rena			Licience		Yes 2 No		bably 4 Unknown
Records,	w raquir been si should	lete	Dementia.		7,00	X	200	ma curo	24a. Was	an 24h	Were out	oney findings available
Re	The la te has age 2	dmo	Deller						auto perf	ormed?	death?	opsy findings available ompletion of cause of
Vital	ian: Trifical	Be C	25. Was case referred to medical					26. Place of Dea		2 🛂 √10	1 🗆 Yes	2 No
) \ \	Physician: this certific ral director,	ToE	examiner? 1 Yes 2 10	fospital: 1   Inpatien	2 ☐ ER/Outpatie	nt 3□ DO	A Othe	er: 4 Nursing H	ome 5 Res	idence 6 🗆 O	ther (Speci	ify)
o uc	ing P	lon:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time of Injury		8c. Injury Work		28d. Describe	how injury occu	ırred	
Division of	death ctor: /	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e Place of Injur	y - At home, farm, st	M factory		Yes 2 □No	28f Location	Street and Nun	nher or Rur	al Route Number,
Div	after after Dira	ertil	4 ☐ Homicide determined	building, etc.	(Specify)	reor, ractory	, 011100		City or To	wп, State)	ibei ei ribi	arriotte rumber,
	pspits hours unaral	Salc	29a. Certifier 1 Certifying Phys	sician: To the best of	my knowledge, dea	th occurred a	at the tim	ne, date and place,	and due to the	cause(s) and n	nanner as :	stated.
	To the Hospital or Attending Physicien: The lav within 24 hours after death. To the Funeral Director: After this certificate has completely illied in by the funeral director, page 2	Medical	one)	ner: On the basis of e and manner state	examination and/or in ed.				red at the time,			
	To To I	2	29b. Signature and title of certifier	ch	- an a	290		5065	3	29d. Date sign		Day, Year)
			OO November of the Control of the Co			División (			0111			~ CO) ~
			30. Name and address of person who co	le Cluv	atri (item 23a) (Type	Print) (	YA	N.C.	sur)	HN H	20	751
	₹ Sta	ite	31. Date filed (Month, Day, Year)	3 Registrar	's Signature	and a	- CA CA			101/		101
, ×	Registr	ar	MOA 0 4 500		15							

		1 - For State Registrar	State of Mary		artment of F rtificate of			005	3772	25
		1. Decedent's Name (First, Middle, La	ist)				2. Date of Death Month	Day Year	3. Time of D	Death
Physic /Medi		Ruth L. Parkes					Oct. 19		8:43	P
Exami		4a. Facility Name (If not institution, git	ve street and number)		4b. City, Town, o	or Location of Death		4c. County of Death	1	
		Holy Cross Hospi	tal		Silver	Spring		Montgomery	J	
uneral				yrs. last birthday,	If Under 1 Year   Months   Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birth	place (State or intry)	Fore
irector		205-10-1986	1 M 2 F	88 Yrs.	World S Days	Tiodis iviii.	Dec. 31,		nnsylvai	
>00		Usual Residence of Decedent  10a. State 10b. County	10	c. City, Town or L					10d. Inside City	. 1 7
Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f ehow any injury or other traumatic event, the Mudical Examinations instituted at once.	_								1 GYes	•
Ba-f	Director	Maryland Montgom	ery	ilver Sp						
0r2	5	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Cou	intry?	
238 UST	<u>ra</u>	3128 Gracefield R	· · · · · · · · · · · · · · · · · · ·		20904			J.S.A.		
teme	by Funeral	11. Marital Status	12. Was Decedent Ever Armed Forces?	r in U.S. 13.	Was Decedent of H If Yes, specify Cubi	Hispanic Origin? (Span, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White		
Po.	V F	1 Never Married 2 Married	1 ☐ Yes Z∏ No If Yes, Give		1 ☐ Yes 2 ☐ No	Specify:		Specify: Wh	te	
ural'		3 Widowed 4 □ Divorced	Year or Dates:	1 10 5						
nat	lete	15. Decedent's E (Specify only highest gi	ducation ade completed)	16a. Dece (Give	edent's Usual Occup kind of work done	pation during most of work d)	ing	6b. Kind of Business/I	ndustry	
than the	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)				11	lealthcare		
her 1		17. Father's Name (First, Middle, Las	4	Regis	tered Nu		e (First, Middle, Ma	overnment		
evel	Be		9					aiden Sumame)		
Merke	10	Walter Fisher				Ella Mei				
is n		19a. Informant's Name/Relationship	•					City or Town, State, Z		
m 27		Joel L. Parkes /						os, Califo		)0
E E		20a. Method of Disposition  1 🕅 Burial 2 🗀 Cremation 3 E	Removal from State	cemetery, cre	osition (Name of matory or other place	Nov.		Oc. Location - City or T	own, State	
# # B	,	`4 ☐ Donation 5 ☐ Other (Special		Arlingto	n Nat'l C	Cem. 200	)5 A	rlington,	Virgini	Ĺа
Depart Import any inj once.		21. Signature of Funeral Service Lice	nsae					er's Sons,		
2 E E 8		riceh M.	Sacso	5	130 Wisco	onsin Ave.	, N.W. W	ashington,	D.C. 2	20
ysician Medical kaminer		disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Ulsease or injuly that initiated events	b. Cardiomy of Due to (or as a co	ensequence of):						
ed by the attending physician and detached for use as the burial-transit	Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	Due to (or as a co	regnancy	□Ectopic pregnanc □ Other (specify)	у		23d. Date of deliv		ear
ned t	by P	Part II. Other significant conditions	contributing to death but no	ot resulting in the t	underlying cause giv	ven in Part I.	23e. Did toba	icco use contribute to	the cause of de	ath
n signe							1 🗆 Yes	2 □ No 3 □ Pro	bably 4XIUr	nkn
been signal	Completed						24a. Was an	24b. Were aut	opsy findings av	vail
page 2 s	Ę						autopsy performe	prior to c	ompletion of cal	use
cate r. pa			1					No 1 ☐ Yes	2 No	
is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital: X.		nt all pos Oth	200	n (Check only one)			
this ral dir	To	1 Yes Z No	1 Enpatient	2 ER/Outpatie	all SI DOA	4   Nuising no		ce 6 Other (Spec	ify)	_
Ter De	ou	27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day Ye	ar) 28b. Time o	Wor	rk?	28d. Describe how	rinjury occurred		
tor: / the	ficat	2 Accident investigated 3 Suicide 6 Could not 1	28e. Place of Injury	At home, farm, st		Yes 2 □ No	28f. Location (Stre	et and Number or Ru	al Route Numb	er,
Dire	Certification:	4   Homicide	building, etc. (S				City or Town,		atana d	
eral filled	Ca	(Check only 2 Medical Exa	miner: On the basis of exa and manner stated.	amination and/or in	nvestigation, in my o	opinion, death occurr	ed at the time, dat	e and place, and due	to the cause(s)	
n 24 hours and Funeral state of filled	B				29c. Licens	se number	290	d. Date signed (Month	Day, Year)	
vithin 24 hours after d To the Funeral Direct completely filled in by	Medical	29b. Signature and title of certifier								
To the Funeral completely filled	Medi	29b. Signature and title of certifier  Ta dmela tha	m-D		Doo	60038	1	0/20/05	-	
To the Funeral completely filled	Medi	P7111	completed cause of death		, Print)	· ·				

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of	Maryland / De	epartment of Certificate				iene	5 3	17726
	ž Ž	A	1. Decedent's Name (First, Middle	, Last)					2. Date of Deat	h		3. Time of Death
	Physici /Medi		KIEN QUANG	PHAM					Month October	30	Year 2005	12:17 P <sup>M</sup>
	Examir		4a. Facility Name (If not institution	give street and nun	nber)	4b. City, To	wn, or Locat	tion of Death		4c. Count	y of Death	1202/
			Shady Grove Ad	lventist H	ospital	Rocl	kville			Mont	gomer	·v
ij	Funeral	П	5. Social Security Number		7. Age (In yrs. last birtho			nder 24 Hrs.	8. Date of Birth			ace (State or Foreign try)
	Director		614.68.5375	1⊠M 2□F	50 Yrs	. Months E	Days Hou	urs Min.	(Month, Day, March 1	1.1955	Viet	ny) nam
	pu ,		Usual Residence of Decedent									
	aryla show	_	10a. State 10b. County		10c. City, Town o						10	Od. Inside City Limits
	Ba-f	cto	Maryland Monte	omery	Gaithe	rsburg						1 ☑ Yes 2 ☐ No
	or 2	D.	10e. Street and Number			10f. Zip Co			10	og. Citizen of	Whal Coun	try?
	ath v	Funeral Director	9130 Emory Grov			208	377			U.S.A		
	tarme	nue	11. Marital Status	Armed For	dent Ever in U.S. ces?	<ol> <li>Was Deceden If Yes, specify</li> </ol>	t of Hispanio	o Origin? (Spe xican, Puerto I	cify Yes or No- Rican, etc.)		ce - America	
36	be filed within 72 hours after death with the Maryland ital Hygiene and other than "natural", or Itame 23e or 28e-f show event, the Medical Exeminar must be notified at	by F	1 ☐ Never Married 2 ☑ Marri 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	9	1 ☐ Yes 2 🔀	No Spe	icity:			y Asia	
21215-0036	hour	D D		Year or Da								
5	- 0 22	Completed	15. Decedent (Specify only highes	s Education t grade completed)	(0	ecedent's Usual C live kind of work of e. DO NOT use i	done durina i	m <i>ost of workir</i>	ng 1	16b. Kind of E	Business/Ind	ustry
12	within ene.	m d	Elementary/Secondary (0-12)	College (1-3 Yea	4or 5+)		,		T	S Po	ctal	Service
	filed within Hygiene. other than ent, the M		17. Father's Name (First, Middle, I		1.5	Mail Han		Inther's Name	(First, Middle, M			DEL ATCE
an	Mental Merked o	Be	Trung Pham							ialuen Sunial	110)	
2	S should be filed within and Mental Hygiene. Is marked other than eumatic event, the Manager and the Manager a	2	19a. Informant's Name/Relationsh	in (Type Print)	19h M	ailing Address (S		ghia	Nguyen	City or Town	Charles 7:-	C=#=)
Maryland	is 1 and 2 should of Health and Men item 27 is marke other treumatic									-		,
	1 and 2 Health tem 27		Luu Quang Pha 20a. Method of Disposition	.111/ 5011	20b. Place of Di	0 Emory sposition (Name	of	Road,		Sbur		
9	Pages nent of int: If it		1 ⊠ Burial 2 ☐ Cremation		state cemetery,	crematory or othe	r place)					
Baltimore,	- 5 P - 3"		4 ☐ Donation 5 ☐ Other (Sp. 21. Signature of Funeral Service L		Gate of	Heaven			/2005	Silver	Sprin	MD
Ba	Departition Department imports any old		21. Signature of Fulleral Service D		+.	22. Name and A	INALDI	FUNER	AL HOME,	INC.		,MD 20904
			23a. Part1. Enter the disease, or	, lecan	wood the death. Do set	11800 Ne	ew Ham	pshire	Ave, Si	llver S		
-89			shock, or neart failure. List of	only one cause on ea	ich line.	enter the mode o	aying, sucr	n as cardiac o	r respiratory arre	St,		Approximate Interval Between Onset and Death
· 第	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	_ a Ac_	or as a consequence of):	cordia	In m	Forcti	6			とうしゅう
	Examiner		,	Due to (d								
		er	Sequentially list conditions, if any, leading to immediate	b. At	or as a consequence of):	effe (	won	try A	rtery 1	), seas	R	mys
	led nsit	ulu ulu	cause. Enter Underlying Cause (Disease or injury	Du e Du	as a consequence on).				9			
	xecu and	Examin	that initiated events resulting in death) Last	c. Due to (c	or as a consequence of);							
68760,	icate be executed physician and s the burial-transit	alE										
387		dlcal		d						-		
	The law requires that the death certifi tie has been signed by the attending page 2 should be detached for use as	/Me	IF FEMALE:	23c. If yes, outc	ome of pregnancy							
Вох	atter for u	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 Live bit	th 2 Fetal death	3 □Ectopic pregr 5 □ Other (specif					te of deliver onth	y Day Year
P.O.	the d	ysle	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unkno		3 Collier (specii	(y)					
	res that the de signed by the a be detached i		Part II. Other significant condition	s contributing to dea	ath but not resulting in th	e undertving caus	e given in Pa	art I.	23e. Did toba	acco use con	ribute to the	cause of death?
ds,	sign d be	d by	Cerek		Mag. Fd 5 m	^	<b>3</b>		1 □ Yes	/		bly 4 Unknown
Š	w requir been si should	ete	11		31.000 131							
Division of Vital Records,	has has	Completed	17/2	ertensi	CH				24a. Was an autopsy		prior to com	sy findings available pletion of cause of
ë									perform 1 Yes 2		death? 1 □ Yes 2	?□ No
Z.	Physician: This certifical	Be	25. Was case referred to medical examiner?	Hospital:			Other		(Check only one			
of	₩ w <del> </del> <del> </del> <del> </del> <del> </del> <del> </del> <del> </del> <del> </del> <del> </del> <del> </del> <del> </del>	은	1 Yes 2 No	1 🗀 In	patient 2 ER/Outpa				ne 5 Residen			
L C	g je e	<u>o</u>	1 Natural 5 ☐ Pending		Injury 28b. Time , <i>Day Year)</i> Injur	у	Injury at Work?		8d. Describe how	v injury occur	red	
Si	Attending ir death. ector: After by the fune	icat	2 Accident investigation inves	ot he	61=1	М	1 ☐ Yes 2					
i≥	or A after Direct in by	Certification:	4 Homicide determine	ned 289. Place o	of Injury - At home, farm, g, etc. <i>(Specify)</i>	street, factory, of	TICE	2	8f. Location (Stre City or Town,	et and Numb State)	er or Rural.	Route Number,
_	pital ours erel filled	Ö	29a. Certifier 1D Certifying	Physician: To the	post of my knowledge, d							
	24 hc 24 hc Fun stely	ledical	(Check only 2 Medical E	xaminer: On the bas and manner	pest of my knowledge, desis of examination and/o	investigation, in	ne time, date my opinion, c	e and place, a death occurre	nd due to the cau d at the time, dat	use(s) and ma le and place,	anner as sta and due to t	ted. he cause(s)
	To the Hospital or Attendii within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Mec	29b. Signature and title of certifier	and mailine		29c. Li	cense numb	er	،٥٠	d. Date signe	d (Month D	av Year!
1	- 3 + ŏ		11.	0	C mo					. i i		0.
•	10		20 Nordo and addition of a	- 1 V			058	~47	000	tober	30	7007
			30. Name and address of person w	mo completed cause M. Wer	or death (Item 23a) (Typ	pe, Print)	1	10	1	0	1- 11	20820
di	Sta	te	31. Date filed (Month, Day, Year)		gistrar's Signature	1701 19	1691 Ca	4 Cen	ur Ur	, Koc	KVII	le, MD
	Registr		NOV 0 4	2005	us Is his	MARC!						

			For State Registrar	State of	Marylan		artment rtificate				lental Hy	gierye	UUL	5 3	3772	27
	Physici	an	Decedent's Name (First, Middle, L								2. Date of De Month	eath Da		Year	3. Time of	
	/Medic Examir	al	Milton Pochte  4a. Facility Name (If not institution, g		ber)		4b. City.	Town, or	Location of	of Death	Octobe		31, 20	005 f Death	05:1	LO_A <sup>M</sup> _
1	LAGIIII	IGI	1801 E. Jeffers	on St. Ap	t336		Rock					M	iontge	omer	У	
	Funeral			Sex 7 1⊠M 2□F	. Age (In yrs.		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi	ay, Year)	010	9. Birthp Coun	lace (State o	or Foreign
	Director		324-22-6901 Usual Residence of Decedent			87 <sup>Yrs.</sup>					Jan. 2	23, 1	918	Iow	a	
	72 hours after death with the Maryland natural', or Items 23a or 28a-1 show diral Examinar must be notified at	_	10a. State 10b. County		10c. Cit	y, Town or Lo	ocation							1	0d. Inside Ci	
	he Ma 28a-1	Funeral Director	Maryland Montgo	nery	Ro	ckvill		^ .							1 Tes	2 X No
	with t	Dir	1801 E. Jefferso:	n St. Ant	336		10f. Zip	2085	2			10g. Cii	tizen of Wh	nat Coun	try?	
	death	nera	11. Marital Status	12. Was Deced	ent Ever in U.	.S. 13.				gin? (Spe	ecify Yes or No Rican, etc.)		14. Race			
98	or Ite	y Fu	1 Never Married 2 Married	1 Tes 2	<b>⊠</b> No	ĺ	ires,spec 1∐ Yes 2		Specify:		Hican, etc.)		Specify:	, White,	etc.	
21215-0036	hours fural',	ed by	3   Widowed 4 □ Divorced  15. Decedent's	Year or Dat	es:		dent's Usua					165 K	ind of Bus		ite	
215	within 72 ene. than "na	plet	(Specify only highest of Elementary/Secondary (0-12)		lor 5+)	(Give	kind of wor DO NOT us	k done d e retired	<i>uri</i> ng mosi )	t of worki	ng	10b. K	and or bus	mess/mc	Justry	
21	ad with	Completed		5+		Busin	essma	n					1f Er		yed	
nd	be file	Be	17. Father's Name (First, Middle, La.	it)							(First, Middle	, <i>Maid</i> en	Sumame,	)		
Maryland	12 should be filed within h and Mental Hygiene. 7 is marked other than "Iraumatic avent, Iraumatic	은	Samuel Pochter  19a. Informant's Name/Relationship	(Type Print)		19h Mailir	na Address				enberg J Route Numb	or City o	or Tourn S	tato Zin	Code	
	nd 2 salth an 27 is r trau		Mrs. Suzanne Bro		ughter											
ore,	of Hear		20a. Method of Disposition		20b. F	lace of Dispo	sition (Nam	e of			ate		ocation - C			
Ë	artment ortant: If injury a		1 XBurial 2 ☐ Cremation 3 `4 ☐ Donation 5 ☐ Other (Spec		ате	ng Dav	id Me	m. P	ark			Fa11	s Chu	ırch	. VA	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury op other traumatic event. The Medical Examinar must be routined at once.		21. Signature of Funeral Service Lic								es-Rin Ave. S					
8760,	Centificate be executed with the principle of the princip	cal Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Une also in hury that initiated events resulting in death) Last	b. Due to (or	ry Art ras a consequence as a consequenc	uence of): uence of):	sease									
9	artificat ing phy e as th	Medi	IF FEMALE:													
.O. Box	death e atter id for u	Physician/Medical	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown		h 2 ☐ Fetal nt at time of de	death 3	Ectopic pre Other (spe						23d. Date Month		*	/ear
4	requires that the een signed by th hould be detache		Part II. Other significant conditions	contributing to dea	th but not resi	ulting in the u	nderlying ca	use give	n in Part I.		23e. Did t	obacco u	se contrib	ute to th	e cause of de	eath?
ords	w requires that been signed b should be deta	ted t	Upper respiratory	tract i	nfecti	on					1 🗆 '	Yes 21	<b>⊠</b> No 3	☐ Proba	ably 4 □U	Inknown
Records,	> 4 50	Completed by	Congestive heart	failure							24a. Was	psy	24b. We	ere autop	sy findings a	available ause of
al R	Th ate pag		Atrial fibrillat:	on								rmed? 2 🔀 No	dea	ath? ] Yes	2□ No	
Vital	Physician: The this certificate all director, pag	Be	25. Was case referred to medical examiner?	Hospital:			-5	Othe			(Check only o					
o	ding h. After funer	tion; To	1 ☐ Yes 2 ☒ No  27. Manner of Death  1 ☒ Natural 5 ☐ Pending 2 ☐ Accident investigati	28a. Date of (Month,		ER/Outpatien 28b. Time of Injury		Bc. Injury Work	4 🗆 1901	2	ne 5 X Resi 28d. Describe				)	
Division	P afte	Certification:	3 Suicide 6 Could not determine	be 28e. Place of building	f Injury - At ho , etc. <i>(Specif</i> y	ome, farm, str	eet, factory,	office		2	28f. Location (: City or Tox	Street an wn, State	d Number )	or Rural	Route Numb	ber,
	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	edical	29a. Certifying F (Check only one)  1  Certifying F 2  Medical Ext	hysician: To the buminer: On the bas and manne	is of examinat	wledge, death tion and/or inv	occurred a	it the time in my op	e, date and inion, deat	d place, a	and due to the ed at the time,	cause(s) date and	and mann place, and	ner as sta d due to	ated. the cause(s)	1
	To t To t	Σ	29b. Signature and title of certifier	~ \	M			License					e signed (	Month, E	ay, Year)	
•	5		125	7301/0				0578	84			11/	1/05			
			30. Name and address of person who					C+	D = -1-		. 36	1 -	1 000 E	F 0		
	Sta	-	Damien J. Doyle, 31. Date filed (Month, Day, Year)		JI <u>Eas</u> Jistrar's Signa		erson	SC;	KOCK	VITT.	e, Mary	yıand	1 208	52		
	Registr		NOV 0 4	2005	Care I	SX ASS	MASK!									

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiere of Communications.

		•	For State Registrar	State of Man			or Health a e of Death	ina me		lenge 0 0 5	37728
			1. Decedent's Name (First, Middle, Las	it)				2	Date of Deati	h Day Year	3. Time of Death
	Physici /Medic		Gail Ann F	ate						r 7, 2005	12:00A M
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, T	Town, or Location of	f Death		4c. County of Dea	ath
			Kline Hospice				Airy			Freder	
	Funeral		5. Social Security Number 6. Se	□M 2ME	In yrs. last birthday		1 Year If Under 2 Days Hours	Min.	. Date of Birth (Month, Day,	Year) 9. Bi	rthplace (State or Foreign country)
	Director		247-72-8448 Usual Residence of Decedent		63 Yrs.			Ma	arch 12	, 1942 Ne	w York
	and		10a. State 10b. County	1	0c. City, Town or L	ocation					10d. Inside City Limits
	Mary	5	Maryland Frederi	ck	Free	derick					1 ⊠Yes 2 □ No
	death with the Maryland me 23a or 28a-f ahow rmust be notified at	Director	10e. Street and Number	CK	116	10f. Zip (			10	og. Citizen of What C	ountry?
	3a or	□	3013 Arbor Squar	o Drivo			21701			United St	
	me 2	Funeral	11. Marital Status	12. Was Decedent Eve	er in U.S. 13.	Was Decede	ent of Hispanic Origify Cuban, Mexican,	gin? (Specif	fy Yes or No-	14. Race - Am	erican Indian,
٥	after or its	교	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No				, Puerto Rio	can, etc.)	Black, Wh	
3	be filed within 72 hours after death with the Marylar ital Hyglene. Id other than "naturel", or itame 23s or 28s-f shows avent, the Medical Examinar must be notified at	1 by	3 ☐ Widowed 4 ☒ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2	No Specify:			Specify:	White
ָה ה	72 h	Completed	15. Decedent's Ed (Specify only highest grades)	ucation de completed)	16a. Dece	edent's Usual	Occupation k done during most	of working	1	16b. Kind of Business	s/Industry
9500-61212	within 72 ene. than "nai	du	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use	e retired)				
	filed w Hygier other th	S		4	Inst	urance				Insurar	nce
	ild be fil lental H ked otl ic avan	Be	17. Father's Name (First, Middle, Last)							faiden Sumame)	
3	2 should be and Ment is marked reumatic a	T <sub>o</sub>	Pryor Pate					gne En			
Maryland	12 st		19a. Informant's Name/Relationship (7							City or Town, State,	
	s 1 and 2 should f Health and Mer itam 27 is marke other treumatic		Lynn Van-Derpoel		20b. Place of Disp			y Fr		K, Marylan	
Baltimore,	nt of 1		1 ☐ Burial 2 🖾 Cremation 3 🗌	Removal from State	cemetery, cre	ematory or oth	her place)	Novemb	er		
	it. Partmer rtent rtent njury	i	4 □ Donation 5 □ Other (Specify  21. Sign rure of F neret-Service Licen		FRederic		atory   Address of Facility	8, 20		rederick,	
g	permit. Pages 1 an Department of Heall Importent: If itam 2 any injury or other once.		1000	4				Dead		uneral Hom erick, Mar	nes, P.A. cyland 21702
			23a. Part1. Enter the disease, or comp shock, or heart failule. List only	olications that caused the	e death. Do not en	iter the mode	of dying, such as o	cardiac or r	espiratory arre	st,	Approximate Interval Between
ì	Physician		Immediate Cause (Final disease or condition	SMALL			VG CAT				Onset and Death
,	/Medical		resulting in death)	Due to (or as a c			,				1/2
	Examiner		Sequentially list conditions,	b							
	sit ad	Examiner	n any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a s	oneaquanea of):						
	and tran	каш	that initiated events resulting in death) Last	c. Due to (or as a c	carcacuanca of):						
Ď,	ifficate be executed g physicien and as the burial-transit	a E		500 10 (01 43 4 0	onsuquence or,						
08/PN	physicate the	edical		d							
			IF FEMALE:	23c. If yes, outcome of	pregnancy					22d Date of de	li
X Q Q	death cer e ettendir d for use	clar	in the past 12 months?	1 Live birth 2 ( 4 Pregnant at tim	Fetal death 3	□Ectopic pre □ Other (spe				23d. Date of de Month	Day Year
j.	the d y the ached	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown							
<u>.</u>	that hed b	by P	Part II. Other significant conditions co	ontributing to death but r	not resulting in the t	underlying ca	use given in Part I.		23e. Did tob	acco use contribute t	o the cause of death?
cords,	n requires that the de been signed by the should be detached	D D							1 ☐ Ye	s 2 □ No 3 □ P	robably 4 Dunknown
ပ္ပ	law re es bee 2 shor	Completed							24a. Was an		utopsy findings available
Ž	sician: The law certificate hes t irector, page 2 s	E O							autopsy perform 1 Yes 2	prior to death?	completion of cause of
Vital	rtifica	0	25. Was case referred to medical				26. Place	of Death (C	Check only one		2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2
-	ding Physician: th. : After this certifica : funeral director, p	ToB	examiner? 1 Yes 2 No	Hospital: 1 🗌 Inpatient	2 ER/Outpatie	nt 3 DOA	Other: 4 Nur	rsing Home	5 🗆 Resider	nce 6 Dether (Spe	HOSPICE
Ö	ng Ph Iter th		27. Manner of Peath 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Y	ear) 28b. Time o	of 28	c. Injury at Work?	280	d. Describe how	w injury occurred	House
<u>0</u>	endir eath. or: Al	atk	2 Accident investigation			М	1   Yes 2   N	No			
UIVISION	iract	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (	<ul> <li>At home, farm, st Specify)</li> </ul>	reet, factory,	office	28f	Location (Str. City or Town,	eet and Number or F State)	ural Route Number,
2	pitei ( urs al srai D		00-0-0-0-0	1							
	To the Hospitei or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical	29a. Certifier 1 ☐-€€rtifying Phyone) 2 ☐ Medical Examone)	ysician: To the best of n iner: On the basis of ex and manner stated	amination and/or in	in occurred a nvestigation, i	it the time, date and in my opinion, death	a place, and h occurred	due to the car at the time, da	use(s) and manner a te and place, and du	s stated. e to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	MD		29c.	License number			d. Date signed (Mon	
)				1 4 4 3		لا	0.05631	4	No	VEMBER -	7, 2005
	12		30. Name and address of person who o		h (Item 23a) (Type NAS TOHN:		DIVE C	0	Pics	MD 2170	7.2
	- 64	10	BINDU GEORGE  31. Date filed (Months Pery; Year)	7 ~ -	Signature .	nd .		- EVE	RICK	NU 411	-
	Sta Registr	_	31. Date filed (Month Nex: Year)	2005 32. Redistrar's	w st	Anosti.	1				

			1- For Amend Item 24a per Dr., G849, II.	artment of Health and Mer 22/05dhb rtificate of Death	ntal Hygier	
	Physici		1. Decedent's Name (First, Middle, Last)  ELSIE LEE PYLES		Date of Death Month	3. Time of Death 2005 10:23P M
)	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
313			21400 PEACHTREE RD.	DICKERSON		MONTGOMERY
	Funeral		5. Social Security Number 6. Sex 1 I M 2 F 7. Age (In yrs. last birthday) 84 Yrs.	Months Days Hours Min.	Date of Birth (Month, Day, Yea	
	Director		218-12-0126	M.F.	AR. 17	1921 MD
	nyland how		10a. State 10b. County 10c. City, Town or Lo	ocation		10d. Inside City Limits
	8a-fs	Director	MD MONTGOMERY DICKERS			1 □ Yes 2 No
	with the		10e. Street and Number 21400 PEACHTREE RD.	10f. Zip Code	10g.	Citizen of What Country?
	ns 23	Funerai	11 Marital Status 12. Was Decedent Ever in U.S. 13.	20842 Was Decedent of Hispanic Origin? (Specify	v Yes or No-	USA  14. Race - American Indian.
36	be filed within 72 hours after death with the Maryland stal Hyglene. id other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show evant, ite Medical Eracid at Iranal Le rodified at	by Fun	Armed Forces?	If Yes, specify Cuban, Mexican, Puerto Ric	an, etc.)	Black, White, etc.  Specify: WHITE
21215-0036	2 hou	ted !	15. Decedent's Education 16a. Dece	dent's Usual Occupation	16b	. Kind of Business/Industry
218	within 7 ene. than "n	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	kind of work done during most of working DO NOT use retired)	ъ	OARD OF EDUCAMEON
21	filed wi Hyglen other th			INISTRATIVE SECRE	TARY	OARD OF EDUCATION
Maryland		Be	17. Father's Name (First, Middle, Last)  ALFRED WOOD	18. Mother's Name (F		
ary	₹ Ø E E	ဥ		JESSIE P ng Address (Street and Number or Rural R		
	as t and 2 s of Health an litem 27 is rothar trau		JIM CARLIN / NEPHEW 1241	7 KEENELAND PL.,	N. PO	TOMAC, MD 20878
Baltimore,			20a. Method of Disposition   20b. Place of Dispo	osition (Name of Date matory or other place)	20c.	Location - City or Town, State
Ħ.	tment of I tant: If it		`4 Donation 5 Other (Specify) MONOCACY	CEMETERY 11/12	/05 B	EALLSVILLE, MD
Bal	permit. Pag Department Important: I any injury o		MAN AM	2. Name and Address of Facility  IILTON FUNERAL HO	ME	20838
L			23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac or re	espiratory arrest,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	AILURE		Onset and Death
	/Medical Examiner		Due to (or as a consequence of):	Black		
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Block ENGCON		
	cuted nd ransit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	ENGLON		
90,	icate be execute physician and the burial-trans	i Ex	resulting in death) Last Due to (or as a consequence of):			
8760	physic the p	dicai	d			
Box 6	eath certific attending p	√Me	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery
	death e atte	Physician/M	in the past 12 months?  1 Yes 2 No  4 Pregnant at time of death 5			Month Day Year
P.0	at the de I by the a stached	hys	9 ☐ Unknown 9☐ Unknown			
	The law requires that the death certificate be executed tte has been signed by the attending physician and page 2 should be detached for use as the burial-transit	by	Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause given in Part I.	23e. Did tobacc	2 ■No 3 Probably 4 □Unknown
Records,	w require been sig	Completed	1 40 (40)		24a. Was an	24b. Were autopsy findings available
Re	The lav	dmo			autopsy perfor <u>me</u> d	prior to completion of cause of death?
Vital		Φ	25. Was case referred to medical	26. Place of Death (C	1 Yes X	No 1 ☐ Yes 2 ☐ No
of V	i ya	To B	examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 EP/Outpatier	nt 3 DOA Other: 4 Nursing Home	5 Residence	6 ☐Other (Specify)
	ng ff ine	on:	27. Manner of Death 1 ■Natural 5 □ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	Work?	. Describe how in	njury occurred
Division	Attending r death. ector: After by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be determined determined	M 1 Tyes 2 No	Location (Street	and Number or Rural Route Number,
Ω̈́	after after Direction	Certification:	4 Homicide determined building, etc. (Specify)	iosi, radioty, office	City or Town, St.	
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical C	29a. Certifier (Check only (2) Medical Examiner: On the basis of examination and/or in	th occurred at the time, date and place, and	due to the cause	e(s) and manner as stated.
	To the h within 24 To the F complete	Medi	one) and manner stated.  29b. Signature and title of certifier.	29c. License number	r	Date signed (Month, Day, Year)
	To To		Mega Assurance IW	7	ub 230	16 / 14 = 200
7			30. Name and address of person the completed cause of death (Item 23a) (Type,	P ( P ( ) P	11	LUVIT COUG
	77.5		17600 Wear Willpro	KD / 9/00/49	ville	MV 20837
	Sta Registi		31. Date filed (Month, Day, Year) 32. Registar's Signature	food		

# Charles T. Potter

Baltimore, Maryland 21215-0036

			1 - For State Registrar		epartment of Health and Certificate of Death	Mental Hygien	.000
			1. Decedent's Name (First, Middle, La.	st)		2. Date of Death	3. Time of Death
	Physici /Medio		Charles Tho	mas Potter		October	31 2005 2:35d
	Examir		4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of Dea		4c. County of Death
			Manokin Manor Nu	rsing Home	Princess Anne		Somerset
	Funeral		Social Security Number     6. S		Months Days Hours Mir	s. Date of Birth	9 Hirthplace /State or Foreign
	Director		037-18-4/35	78 Y	rs.	01-21-192	27 Rhode Island
	and *		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town	or Location		10d. Inside City Limits
	Aaryll Fsho	ō		,			12 Yes 2 No
	286-1	ect	MD Baltimor  10e. Street and Number	e White	Marsh 10f. Zip Code	100.6	Citizen of What Country?
	with Mary	ā	11119 Pulaski Hig	huzov	21162		
	ns 23	era	11. Marital Status	12. Was Decedent Ever in U.S.			USA  14. Race - American Indian,
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "naturel", or Items 23a or 28e-f show eumatic event, it a Marical Eventration to the north of a	Completed by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: WWII	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue 1 ☐ Yes 2 No Specify:	nto Rican, etc.)	Black, White, etc.  Specify:
5-0036	ture sture	edl	15. Decedent's Ed	lucation 16a. E	Decedent's Usual Occupation	16b	White Kind of Business/Industry
15	n "ne	plet	(Specify only highest gra	de completed) (	Give kind of work done during most of w life. DO NOT use retired)	orking	Tund of Dusinessamoustry
2121	within jiene. r than *	mo	Elementary/Secondary (0-12)	College (1-4or 5+) none	ruck Driver	Fr	eight
b	e filed Il Hygie other	Be C	17. Father's Name (First, Middle, Last)			ame (First, Middle, Maide	
<u>la</u> r	Aental Aental rked c	To B	Frederick C. Pot	ter	Blandir	e J. Plante	
Maryland	2 should and Men is marke eumatic	Γ.,	19a. Informant's Name/Relationship (	Type, Print) 19b. I	Mailing Address (Street and Number or F	Rural Route Number, City	or Town, State, Zip Code)
	and 2 ealth n 27 i		Shirley Massey/N	iece 232	55 Haines Point Ro	ad, Chance,	MD 21821
Baltimore,	ges 1 It of H If iter or oth		20a. Method of Disposition  Burial 2 □ Cremation 3 □  '4 □ Donation 5 □ Other (Specifi	Removal from State 20b. Place of Cometery,	Disposition (Name of crematory or other place)	Date 20c.	Location - City or Town, State
Ħ	permit. Pa Departmen Importent: any injury once.	1	21 Signature of Funeral Service Licer	L KOCK L	reek Cemetery 11- 22. Name and Address of Facility	07-2005 Ch	ance, Maryland
Ö	permit. Departr Importe any inju	(	Draw L Klund	76 \ X/	22. Name and Address of Facility Hinman Funeral Hom		
			3a. Part1. Enter the disease, or com	M00295  Olications that caused the death. Do no	11673 Somerset Ave tenter the mode of dying, such as cardi-	<ul> <li>Princess ac or respiratory arrest,</li> </ul>	Approximate
	hysician.	0	Immediate Cause (Final				Interval Between Onset and Death
7	/Medical	ì	disease or condition resulting in death)	a. Due to (or as a consequence of	VON-SIMALL CELL	e Lune, e	TRICK MONTHS
	Examiner				,		
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of	):		
	ifficate be executed g physicien and as the burial-transit	Examiner	that initiated events	C			
Ó,	e exe	EX	resulting in death) Last	Due to (or as a consequence of)	:		
68760,	ate b hysic the bi	edicai		d			
	ing p		IF FEMALE:				
Вох	eath cert attending for use a	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death	3 ☐Ectopic pregnancy		23d. Date of delivery  Month Day Year
0.	The law requires that the death certate has been signed by the attending page 2 should be detached for use.	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of death 9☐ Unknown	5 Other (specify)		World Day (Sal
Ρ.	that the de ed by the detached	Phy		ontributing to death but not resulting in t	ha uadarhiga anusa guas is Dart I	22a Did tabassa	use contribute to the cause of death?
S	uires tha signed d be det	Completed by	PROSTATE C		ne underlying cause given in Fait i.		2 No 3 Probably 4 Donknown
Record	w requir been s should	etec					2 110 3 1 100dbly 4 1201111101111
ec	ne law has b je 2 s	nple	AIRBETES	MELLITMS		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
<u> </u>		Cor				performed?	
of Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	(1	0.1	eath (Check only one)	
of	Si Si	은	1 Yes 2 146	Hospital: 1 Inpatient 2 ER/Outp		Home 5 Residence	
no U	ling F	lon	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b. Tin	ury Work?	28d. Describe how inj	ury occurred
Division	ittendi death. ctor: A / the fu	Certification:	2 Accident investigation 3 Suicide 6 Could not be		M 1 Yes 2 No	204 1	2.10
Σ	after after Direct I	irtif	4 Homicide determined	28e. Place of Injury - At home, farm building, etc. (Specify)	i, street, ractory, office	City or Town, Sta	and Number or Rural Route Number, te)
	Hospital or Attending 24 hours after death. Funerel Director: After tely filled in by the fune		29a. Certifier 1 V Certifying Ph	unicipa. To the best of my knowledge	death occurred at the time, date and place	and due to the source	.)
	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medical	(Check only 2 Medical Exam	iner: On the basis of examination and/ and manner stated.	or investigation, in my opinion, death occ	curred at the time, date an	nd place, and due to the cause(s)
	To the within 2. To the complet	ž	29b. Signature and title of certifier	/	29c. License number	29d. D	ate signed (Month, Day, Year)
)			•	Jelin & W	000 629	16 NOV.	5m 36R, 01, 2005
			20 November of State				
		18	-	completed cause of death (Item 23a) (Ty	/pe, Print)		
		12		MEZ, M.P. 1415 30  32. Registrar's Signature	ype, Print) BUTH PIGISION SHIT	EB SALISB	uan no 1/804

BARBOUR

			For State Registrer	State of	Maryland	/ Depa	artment of rtificate of	Health if Death	and Mental H	ygiene Reg. No.		37732
			Decedent's Name (First, Middle,	Last)					2. Date of D	eath Day	, Voor	3. Time of Death
	Physicia		Dorothy Mae Rip	ple					Novemb	er 3,	2005	12:40am M
	/Medic Examin	a	4a. Facility Name (If not institution,		ber)		4b. City, Town,	or Location	of Death	4c.	County of Dea	ıth
			Wilson Health C	are Cente	r		Gaither	sburg		Mo	ontgome	ry
	Funeral		5. Social Security Number	6. Sex 1 □ M 25 □ F	7. Age (In yrs. las		If Under 1 Yea Months Day		24 Hrs. 8. Date of B Min. (Month, D	irth Day, Year)	9. Bir	rthplace (State or Foreign ountry)
L	Director		218-09-2335	10 M 26 F	92	Yrs.	,		Mar 2	5, 19	13 Mary	
	and *	1	Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	ocation					10d. Inside City Limits
	Aaryla sho	ō	. 1 1 36		0-4	41	1					1 X Yes 2 □ No
	28e-i	Directo	Maryland   Montgo 10e. Street and Number	mery	Gai	ther	10f. Zip Code	)		10g. Citi	izen of What C	ountry?
	with la or		403 Russell Ave	nue #809			20877			Unit	ed Sta	tec
	ns 23	Funerai	11. Marital Status	12. Was Dece	dent Ever in U.S.	13.			rigin? (Specify Yes or N n, Puerto Rican, etc.)		14. Race - Am	erican Indian,
	ritar	Fun	1X Never Married 2 ☐ Marrie	Armed For ad 1 ☐ Yes	2 XNo	1					Black, Whi	
ğ	al', o	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Da	e ites:		1⊡ Yes 2⊠XN	o Specify			Specify: Wh	ite
2	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or Itams 23a or 28e-f show ont, the Madisal Exaturistic varies invitited at	Completed	15. Decedent' (Specify only highest			16a. Dece	dent's Usual Occ	upation	st of working	16b. Ki	ind of Business	s/Industry
2	ithin le. lan "t	npie	Elementary/Secondary (0-12)	College (1-	4or 5+)	life.	DO NOT use reti	red)	9			
7	ygier ygier yertt		12			Man	nager	40 M-46			stauran	t
<u>n</u>	be fill	Be	17. Father's Name (First, Middle, L	_					er's Name (First, Midd		Surname)	
Maryland 21215-0036	Mer Marke Marke	<sup>2</sup>	Everett Norman			10h Maili	- Address (Care		rrie Campbe Beror <i>Rural Route Nu</i> m		r Tourn State	Zin Cada)
Mai	12 st h and 7 is n traun		19a. Informant's Name/Relationsh		,		•					210 0000)
	1 and Healt am 2 thar		Harry Humphries 20a. Method of Disposition	(Nephew	20b. Plac	ce of Dispo	sition (Name of		Hanover, P	-	ocation - City o	Town, State
סר	nt of its		1 Burial 2 Cremation		State cen	netery, cre	matory or other p		- 11/2/05	1		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23a or 28e-f show amorphism injury or other traumetic avant, the Markical Experiment and the multilitied all annexes.		' 4 ☐ Donation 5 ☐ Other (Sp. 21. Signature of Suneral Service L		Metr	opor:	Name and Add	ress of Facil	y 11/3/05 ny DeVol Fun	eral	Home	, Virginia
Ba	Departiment important		1 10 1021	(1 LAI1			D East D	eer Pa	ny DeVol Fun ark Drive			
			23a Part1. Enter the disease, or shock, or hear tailure: List of	complications that ca	aused the death.		aithersb ter the mode of d			arrest,		Approximate
O.	=		Immediate Cause (Final	only one cause on ea	ach line.	-	10	10	4 0 -			Interval Between Onser and Death
	Fh <del>ysicia</del> n /Medical		disease or condition resulting in death)	a	as a conseque	nce off:	y fee	ceu				, cay
	Examiner			Fel	alisa	Loc	iees	220	nea			
		je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (	or as a correspond	nue of):						
	cuted nd ransit	Examiner	that initiated events	c								
Ó,	e exerian ar	Ë	resulting in death) Last	Due to (	or as a conseque	nce of):						
8760,	icate be executed physician and s the burial-transit	dicai		d								
9	death certific attending p	Med	IF FEMALE:	00-11								1000
Вох	death certific e attending p ed for use as	ian/	23b. Was decedent pregnant in the past 12 months?	1 ☐Live bi	come of pregnand irth 2  Fetal d	eath 3[	Ectopic pregnar			4	23d. Date of de Month	olivery Day Year
0	0 0 0	/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4⊟Pregna 9□ Unkno	ant at time of dea wn	ith 5L	Other (specify)					
٦.	The law requires that the de ate has been signed by the bage 2 should be detached	Completed by Physician/Me	Part II. Other significant conditio	ns contributing to de	ath but not result	ing in the u	inderlying cause	given in Part	I. 23e. Did	i tobacco u	ıse çontribute t	to the cause of death?
ds,	w requires that been signed be should be det	d b	Chimie obst	weet in	e pul.	ins	nacy	Luca		Yes 2	⊡No 3□P	robably 4 Unknown
Records,	v requ	ete	Herperton	inds H	101/1	hal	508	/	24a. W	is an	24h Were a	utopsy findings available
Rec	has ge 2	mp	/ Lancas in	nohl	1	12/2	and b		aut	opsy formed?	prior to death?	completion of cause of
			OF Was some referred to madical	) all	ruces	42	a ca	00 01	1 Tes		1  Ye	s 2□No
₹	Physicien: r this certific ral director.	Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:	npatient 2 🗆 Ef	R/Outpatie	nt 3 DOA	Othor /	e of Death (Check only		G □Othor (Co.	naifu)
of	Phy ar this sral d	T: To	27. Manner of Death	28a. Date o	of Injury 2	8b. Time o			28d. Describe			sony)
on	nding th. :: Afte	ation	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investig		h, Day Year)	I <b>n</b> jury		vork? □Yes 2□	]No			
Division of Vital	Attar r dea actor by the	ifica	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 288. Place	of Injury - At hom	e, farm, st	reet, factory, offic	Э		(Street an		lural Route Number,
ā	s after at Dira	Certification:	4   Homedo	Daliali	1g, etc. (Opocny)				July 6. 7			
	Hospitel or Attanding 24 hours after death. Funaral Diractor: After tely filled in by the fune								nd place, and due to th ath occurred at the time			
	To the Hospitel or Attending Physicien: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	one)	and mann	ner stated.							
	To To COM	2	29b. Signature and title of certifier	410		()	/	ense number			te signed (Mon	
•	6		1/4 Rober			enda	D04	113		моче	mber 3	, 2007
	~		30. Name and address of person v					Ave. G	aithersbur	g, Md	. 2087	7
	Sta	ite.	31. Date filed (Month, Day, Year)		egistrar's Signatu		ask)			J, 110		
	Regist		NOV 0 4	407	men st	A	A					

Registrar

State

29b. Signature and title of centifier

31. Date filed (Month

RICHARD L. GOVGH

0 9

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2005

MD

egistrar's Signature

14 W FREDURICK ST

29c. License number

32171

WALKERSVILLE MD

29d. Date signed (Month, Dev. Year)

8103

		For State Registrar	State of Maryla	and / Dep	artment of F	lealth an Death			37734
		Decedent's Name (First, Middle, La	ist)		ranoate or	Dodin	2. Date of Death	J. No.	3. Time of Death
Physic		Ruth Thelma R	affo				Month November	Day Year 2. 2005	2:10 A M
/Med Exami		4a. Facility Name (If not institution, gir			4b. City, Town, o	r Location of C		4c. County of Dea	
		Lorien Nursing &	Rehab. Center		Columbi	a		Howard	
Funeral			Sex 7. Age (In y	rs. last birthday, Yrs.	Months Days	If Under 24 Hours	Hrs. 8. Date of Birth (Month, Day, )	(ear) 9. Bir	thplace (State or Foreign puntry)
Director		577-90-0433 Usual Residence of Decedent		1			Jan.11,1	.914 Was	hington,DC
yland	Ì	10a. State 10b. County	10c.	City, Town or L	ocation				10d. Inside City Limits
the Marylar 28a-f show	ctor	Maryland Anne Arı	ındel	Seve	rna Park				1 ☐ Yes 2 🙀 No
₩ 9	Director	10e. Street and Number			10f. Zip Code		100	g. Citizen of What Co	ountry?
ier death w Items 23a		786 Stinchcomb Ro			211			USA	
ter de Item	Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in Armed Forces? 1 □ Yes 2 ☑ No	10.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin an, Mexican, P	? (Specify Yes or No- uerto Rican, etc.)	14. Race - Ame Black, Whit	
urs aft	by	3₺Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:		Specify:	Thite
72 hours "neturel",	Completed	15. Decedent's E (Specify only highest gr		16a. Dece	dent's Usual Occup	ation	working 16	6b. Kind of Business	
ithin Per	lg l	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	d)	Working		
filed within Hygiene. Ither than "		12 17. Father's Name (First, Middle, Las	*1	Home	emaker	10 Mathada	Name (First, Middle, Ma	Own Home	<u> </u>
al be findal hed of	Be C						,	aiden Sumame)	
should be nd Mental marked o	To	William Beauregan		19b. Mail	ing Address (Street	E11a	Scott or Rural Route Number, (	City or Town, State.	Zin Code)
0 4 4 4		Ronald Aloysius I	Raffo Son		Stinchcom		Severna Pa		
es 1 and of Health If item 27 or other tr	1	20a. Method of Disposition	208	. Place of Disp	osition (Name of			oc. Location - City or	
Pag nent nent	1	1 ☑ Burial 2 ☐ Cremation 3 [		te of H	eaven emetery		v.7,2005 Si	lver Spri	ng.Marvland
permit. Departr Importe any inji		21. Signature of Suneral Service Lice	nsee			ss of Facility	ns Funeral H	Home, Inc.	,
405 50		Moseit 21	canso	150	00 Univer	sity Bl	vd. W. Silv	zer Spring	,MD 20901
		23a. Part1. Enter the disease, or cor shock, or heart failure. List only	one cause on e in line.	eath. Do not en	ter the mode of dyir	ng, such as cai	rdiac or respiratory arres	it,	Approximate Interval Between Onset and Death
Physician /Medical	_	Immediate Cause (Final disease or condition resulting in death)	a. Stroke						2 months
Examiner			Due to (or as a cons	sequence of):					
	ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a cons	equence of):					
cuted	Examiner	cause. Enter Underlying that initiated events	C						
be executed ician and burial-transit	EX	resulting in death) Last	Due to (or as a cons	sequence of):					
cate be exphysician the buria	dical		d						
leath certifica		IF FEMALE:	23c. If yes, outcome of pre	202004					
the death cer by the attendin	hysician/Me	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 F	etal death 3	☐Ectopic pregnancy ☐ Other (specify)	1		23d. Date of de Month	Day Year
t the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	,	_ Other (specify) _				
The law requires that the death certificate are been signed by the attending physpage 2 should be detached for use as the	by Pl	Part II. Other significant conditions	contributing to death but not	resulting in the u	underlying cause giv	ren in Part I.	23e. Did toba	cco use contribute to	the cause of death?
w require been sig should b		Dementia					1 🗆 Yes	2 No 3 P	obably 4 X Unknown
as been 2 should	Completed						24a. Was an autopsy	24b. Were at	stopsy findings available completion of cause of
The lav	E O				- -		performe	ed?   death?	2 No
VICION: The stock of the stock	Be (	25. Was case referred to medical examiner?					Death (Check only one)		
this aldi	70	1 ☐ Yes 2 ☑ No		ER/Outpatie		4 XI Nursii	ng Home 5 Residen		cify)
ding h. After funer	tion	27. Manner of Death  1   Natural 5  Pending  2  Accident investigation	28a. Date of Injury (Month, Day Year	28b. Time ( Injury	Wor	yat k? Yes 2 ∐No	28d. Describe how	injury occurred	
Attending Physicien: ar death. ector: After this certific by the funeral director,	Certification:	3 ☐ Suicide 6 ☐ Could not	be 28e. Place of Injury - A	t home, farm, st			28f. Location (Stre	et and Number or Ri	ural Route Number,
a afferd	erti	4  Homicide	building, etc. (Spe	ecify)			City or Town,	State)	
ospit hours unere ly fille		29a. Certifier 1 Certifying P	hysician: To the best of my miner: On the basis of exam	knowledge, dea	th occurred at the tir	me, date and p	place, and due to the cau	ise(s) and manner as	stated.
To the Hospitel or Attending I within 24 hours after death. To the Funerel Director: After completely falled in by the funer	ledical	one)	and manner stated.						
To with	Σ	29b. Signature and title of certifier	111 1/1		29c. Licens	se number		d. Date signed (Mont	
		KW				710	///	1000	-,200
5		30 Name and address of person who	completed cause of death (	tem 23a) (Type	HICKI	dra	52: di	ORLI	2,2005 olumbis Ply
S	tate	31. Date filed (Month, Day, Year)	32. Registrar's Si	gnature	1 10			1-27 (	ע נומדמוטיט
		350 1 1/ /1 1/	7/11/11L1 No.	160	ar a marker 1				

		•	1 - For State of N	-	epartment of Certificate of	Health and I If Death		2005	37735
i de la companya de l	Physici /Medic		1. Decedent's Name (First, Middle, Last) TORU 9 VI a	5.	RAO		2. Date of Death Month	Day 4 Year	3. Time of Death
	Examin		4a. Facility Name (If not institution, give areet and number	Genera	4b. City, Town	n, or Location of Deatl	י	4c. County of Dea MONTGOMERY	th
	Funeral Director		5. Social Security Number 6. Sex 7. A 1	nge (In yrs. last birth	nday) If Under 1 Ye Months Da		8. Date of Birth (Month, Day, DECEMBER	9. Bir 6 1937 INDI	thplace (State or Foreign buntry) A
	death with the Maryland me 23s or 28s-f show if must be nullised at	tor	Usual Residence of Decedent  10a. State 10b. County  MD MONTGOMERY	10c. City, Town					10d. Inside City Limits 1 ☐ Yes 2∑No
	or 28a	Director	10e. Street and Number		10f. Zip Cod	ө		Og. Citizen of What Co	
036	or Ite	by Funerai	15912 NARROWS TERRACE  11. Marital Status  1 □ Never Married 2 Amarried  3 □ Widowed 4 □ Divorced  1 □ Yes 22  If Yes, Give Year or Dates	§? ∮No	20906  13. Was Decedent of Yes, specify C	of Hispanic Origin? (Suban, Mexican, Puerl	pecify Yes or No-	14. Race - Ame Black, Whit Specify: AS	encan Indian, e, etc.
1215-0036	within 72 hours ene. than "natural", ne Modice Exe	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-40	r 5+)		cupation ne during most of wor ired)	rking	16b. Kind of Business	ŕ
and z	al Hygi I other ivent, I	To Be Co	5+  17. Father's Name (First, Middle, Last)  VENKAIAH JARUGULA	PF	ROFESSOR		ne (First, Middle, M MMA CHINTA	faiden Sumame)	UCATION
Mary	2 sh and le m		19a. Informant's Name/Relationship (Type, Print) SATYA B. JARUGULA, SPOUSE		,	eet and Number or Ru TERRACE, SIL		City or Town, State, 2	Zip Code)
saitimore,	Pages 1 and nent of Health out; if Item 27 ury or other to		20a. Method of Disposition  1 Burial 2 XCremation 3 Removal from Stat  4 Donation 5 Other (Specify)	20b. Place of I cemetery	Disposition (Name of crematory or other COLN CREMATO	place)	Date 2	BRENTWOOD,	
Balt	permit. Pages Department of Importent: If It eny Injury or o		21. Signature of Funeral Service Incensee	Van	22. Name and Ad 11800 NEW H	dress of Facility HIN AMPSHIRE AVE	ES-RINALDI NUE SILVER	FUNERAL HOME SPRING MD 20	, INC. 904
r	Physician /Medical Examiner		83a. Part1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition resulting in death)  a	ed the death. Do no line.	Arrhyth	dying, such as cardiad		ost,	Approximate Interval Between Onset and Death
, no	cate be executed physician and the burial-transit	i Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  c. Re	is a consequence of			1 (	<b>)</b>	Years
09/89		ledicai	d. 111/h	enscks	he (a	onen 1	Herten 1	Dione	Years
O. Box	it the death certifi by the attending tached for use as	Physician/Me		2 Fetal death at time of death	3 ☐Ectopic pregna 5 ☐ Other (specify			23d. Date of de Month	ivery Day Year
Hecords, P.	The law requires that ite has been signed b age 2 should be deta	þ	Part II. Other significant conditions contributing to death	but not resulting in	the underlying cause	given in Part I.		s 2 No 3 P	the cause of death?
		Completed	Hypertension				24a. Was ar autops perform 1 Yes 2	prior to death?	utopsy findings available completion of cause of 2 No
i Vital	Phyaician: this certific al director,	To Be	25. Was case referred to medical examiner?  1	tient ZUER/Out	patient 3 DOA	Other	ath <i>(Check only</i> one lome 5 ☐ Reside	nce 6 Other (Spe	cify)
Division of	on of the contract of the cont		2 Accident investigation		ijury	njury at Nork? □ Yes 2 □ No	28d. Describe ho	w injury occurred	
DIVE	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A complataly filled in by the fi	Certification:	3 Suicide 6 Could not be determined 28e. Place of I building.	njury - At home, farr etc. (Specify)	m, street, factory, offi	сө	28f. Location (Str City or Town	reet and Number or Ri , State)	ural Route Number,
	To the Hospital or within 24 hours affe To the Funeral Dir complataly filled in	Medical	29a. Certifier   1   Certifying Physicien: To the besicance   2   Medical Examiner: On the basis and manner	of examination and	, death occurred at th For investigation, in n	e time, date and place ny opinion, death occu	, and due to the ca irred at the time, da	use(s) and manner as ite and place, and due	s stated. to the cause(s)
ì	To t To t	Σ	29b. Signature and title of certifier Mccol  Mount for any MGD	Ed Dice		o50410	28	9d. Date signed (Mont	h, Day, Year)
	8		30. Name and address of person who completed cause of	death (Item 23a) (T MGH E	Type, Print)	Prince Phila	De Olnes	MA	
	Sta Regist		31. Date filed (Month, Cay, Year) 32. Reg	strar's Signature	books	Prince Philip			

Phys /Me Exa	edi	cal
Fune		

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "naturel", or Items 23a or 28a-1 show any injury or or Ather transmission.

Baltimore, Maryland 21215-0036

Physica /Medi Exami

Division of Vital Records, P.O. Box 68760,

	4	1- State Of Mary Registrar		rtificate of			leg. No.	31130
ciais		Decedent's Name (First, Middle, Last)				2. Date of Dea Month	th Day Year	3. Time of Death
sicia edic	_	VICTOR HANNA RIZKALI	LAH			NOVEMBER	,	5:00 P M
min	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, o	r Location of Death		4c. County of De	
# y .	/6/4 <u>.</u>	HOLY CROSS HOSPITAL	and the late of	SILVER If Under 1 Year	SPRING If Under 24 Hrs.	1	MONTGOM	
ral		1/XM 2□ F	yrs. last birthday) 54 Yrs.	Months Days	Hours Min.	B. Date of Birth (Month, Day		irthplace (State or Foreign Country)
tor	}	578-74-1676 Usual Residence of Decedent	54			MAY 10,	1951  181	RAEL
4		10a. State 10b. County 10	c. City, Town or L	ocation			<del>.</del>	10d. Inside City Limits
	tor	MARYLAND MONTGOMERY	SILVER S	PRING				1 ☐ Yes 2 💢 No
	irec	10e. Street and Number		10f. Zip Code		1	log. Citizen of What (	Country?
	<u>a</u>	11715 GRANDVIEW AVENUE		20	902		U.S.A.	
	Funeral Director	11. Maritat Status 12. Was Decedent Ever Armed Forces?	r in U.S. 13.	Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puert	pecify Yes or No-		nerican Indian,
	y Fu	1 ☐ Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give		1 ☐ Yes 2 🔀 No			Specify:	
	d by	3 Widowed 4 Divorced Year or Dates:						WHITE
	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of work	king	16b. Kind of Busines	s/Industry
	mc	Elementary/Secondary (0-12) Cotlege (1-4or 5+)		Y FOREMAI	,		OTANT TO	O.D.
		17. Father's Name (First, Middle, Last)	DAKLIN	I POREIR		ne (First, Middle,	GIANT FOO Maiden Sumame)	ענ
	To Be	HANNA YACOUB RIZKALI	ΔЦ		SUAD	II A NINI A	DIGEAL	
	-	19a. Informant's Name/Relationship (Type, Print)		ng Address (Street		HANNA ral Route Numbei	RIZKAL] r, City or Town, State	
		KAREN A. RIZKALLAH/WIFE	11715	GRANDVII	TU DR S	TIVED CD	RING, MD	20002
	Ì	20a. Method of Disposition	20b. Place of Dispo	osition (Name of matory or other pla			20c. Location - City of	
- \		1 XBurial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)		MEM. PAI	,	8/2005	DOCUUTITE	MARYLAND
onc.		21. Signature of Funeral Service Licensee			ss of FacilityHTN	ES-RINAL	DI FUNERAL	HOME, INC.
a		Janes Mell	Jun 11	800 NEW H	!AMPSHIRE	AVE., S	ILVER SPRI	ING, MD 2090
· 10		23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.						Approximate Interval Between
an		Immediate Cause (Final disease or condition VENTRICULA	יוספום פ	τ Α ΤΤΟΝ				Onset and Death
cal		resulting in death)  a. Due to (or as a co		DALLON				SUDDEN
ner		Sequentially list conditions b CORONARY A	RTERY DI	SEASE				2 YEARS
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	onsequence of):					
	Examiner	Cause (Disease or injury that initiated events resulting in death) Last						2 YEARS
		resulting in death) Last Due to (or as a co	onsequence of):					
	edical	d	<del></del>					
8	Me	IF FEMALE:						
5	lan	23b. Was decedent pregnant in the past 12 months?	Fetal death 3	Ectopic pregnanc	1		23d. Date of d Month	elivery Day Year
0	Physiclan/M	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time 9 ☐ Unknown 9 ☐ Unknown	e of death 5 [	Other (specify) _				
8	H H	Part II. Other significant conditions contributing to death but no	ot resulting in the u	inderlying cause giv	ren in Part I.	23e. Did to	bacco use contribute	to the cause of death?
2	d by	NICOTINE DEPENDENCE		, ,		1 🔀 Y	es 2 □ No 3 □ I	Probably 4 Unknown
5	Completed					24a. Was a	245 144	. Assert Confession and John
N D	ш					autops perfor	sy prior to	autopsy findings available completion of cause of
7		25. Was case referred to medical				1 Yes	2 23.No 1 □ Y€	es 2 No
	o Be	examiner?  1 Yes 2 🛣 No Hospital: 1 🗆 Inpatient	2 XER/Outpatie	2 2 DOA O#		th (Check only or		
9	$\vdash$	27. Manner of Death 1 ZNatural 5 Pending (Month, Day Ye	28b. Time o	IL SEL DOA	4 🗀 Nursing n		ence 6 Other (Sp ow intury occurred	ecity)
5	atlo	1 ☑Natural 5 ☐ Pending (Month, Day Ye 2 ☐ Accident investigation	ear) Injury		k? Yes 2 □ No			
2	ifica	3 Suicide 6 Could not be 28e. Place of Injury	At home, farm, st	reet, factory, office		28f. Location (S	treet and Number or I	Rural Route Number,
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2	Medical	one) and manner stated 29b. Signature and title of certifier	-	29c. Licens			9d. Date signed (Mo	
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2		30. Name and address of person who completed cause of death MTCHAFT R DORRTDCF M D 1		•	ATTE OT	WED CDD	TNO 150 00	006
		MICHAEL R. DOBRIDGE, M.D., 1	JAIJ CON	MECTICUT	AVL., SII	JVER SPR	ING, MD 20	906

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

NOV 0 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Physician 2:00 John Hobart Rea Sr. ам 2. 2005 November /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner North East 24 Clearview Avenue If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months 1 X M 2 ☐ F 215-40-0523 62 Director Aug. 18, 1943 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heelth and Mental Hygiene. Intern 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Item 27 is marked other than "natural", or Items 23a or 28a-1 show other traumatic event, the Modical Exp. when must be notified at 1 ☐ Yes 2√☐ No Maryland Cecil North East Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21901 24 Clearview Avenue United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 7 Year or Dates: . Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Automotive Industrial Engineer 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John N. Rea Zora Mae Guthrie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 24 Clearview Ave., North East, Maryland 21901 Barbara Rea/Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition Mayerdale Crematory permit. Pages 1
Department of H
Important: If Ite
any injury or ot
once. November 6, Newark, Delaware 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 2005 21. Signatur of Funeral Service Dicensee 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryland 21901 obel 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final erebrovascular Accident Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Mellitus, Insulin-Dependent Diabetes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed European Discours to the Control of t attending physician and for use as the burial-transit Due to of as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown been sig Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No ymphedema 24a. Was an rector, page 2 s autopsy 1 ☐ Yes 2 X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 | Inpatient Other: 4 Nursing Home Residence 6 Other (Specify) 1 ☐ Yes 2 XNo 2 ER/Outpatient 3 DOA 2 this 28c. Injury at Work? 28d. Describe how injury occurred Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death After Certification: 1 XNatural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Director; 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier ical Vithin 2 the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ٥ anter no D57520 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20 Craigtonn Road-Suite 106, Part Deposit, MD 21904 antermo)

DHMH 17 Rev 1/2001

State Registrar 2005<sup>32. Regultrar's Signature</sup>

State of Maryland / Department of Health and Mental Hygierie ] [] 5 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year Anna Mary Riley 23:30 /Medical 2005 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 294 New Bridge Road Rising Sun
If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Cecil 8. Date of Birth (Month, Day, Year)
Dec. 26, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2**X**F 91 Yrs. **Director** 218-26-6681 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23e or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Cecil Risina Sun 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 294 New Bridge Road 21911 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ 3 X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry within 72 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 12 should be fi and Mental H is marked of William Thomas Kyle ပ Mary Jane Bullock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health ar important: if item 27 is any injury or other trau Mary Ann Foard/Daughter 1809 Liberty Grove Road, Colora, MD 21917 Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Pleasant Grove Cemetery 11-8-05 Peach Bottom, PA 22. Name and Address of Facility R. T. Foard Funeral Home, P.A. 111 S. Queen St., Rising Sun, MD 21911 21. Signature of Funeral Service Licensee ichaid 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Heart Congestive disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed burial-transit Due to (or as a consequence of): attending physician Box 68760 Physician/Medical as the t IF FEMALE use a 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 No Month Dav Year 4□Pregnant at time of death 5 Other (specify) ed by the a detached f P.0. 9 Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 Ø No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed? certificate 1□ Yes 2.0 No 2 🗌 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) P 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 1 🖾 Natural 5 Pending s after death. investigation 1 ☐ Yes 2 ☐ No 2 Accident in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide ö within 24 hours a To the Funerei ( 1 Cartifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 115314 torkas 7 D November 5, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 che supeake Hospice, Elkton, MD 31. Date filed (Month, Day, Year) Seisons Worth arm 32. Registrar's Signature State NOV 0 7 2005 Registrar

Amen item#20, pen/E, 852, 2/1/05 11 Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	1 - State Registrar	<b></b>	Cer	tificate of L	Death	···o····a····y	Reg. No.	105	3/13
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Physician /Medical	FORRES		YFIELD			Octo	ber 3	1,2005	050
Examiner	4a. Facility Name (If not institution, Institution, Algion	val Medial	Conta	541	Location of Death	1	4c. Cou	We now	
Funeral Director	5. Social Security Number  225-28-4288  Usual Residence of Decedent	6. Sex 7. Age (In y	yrs. last birthday) 1 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, Di 09/18/	ay, Year)	Count	ace (State or Fe try) GINIA
yland	10a. State 10b. County	10c.	. City, Town or Loc	cation				10	Od. Inside City L
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siter deeth with the Mar or Itame 23a or 28a-fe uiner must be notified Funeral Director	2237 WORCESTI	ER HWY.			1851			U.S.A.	try?
by	11. Marital Status  1 Never Married 2 Marrie  3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces?  1 ☑ Yes 2 □ No U If Yes, Give COast	J.S. Guard 1	Vas Decedent of Hi Yes, specify Cuba ☐ Yes 2 No	ispanic Origin? (S in, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)		Race - America Black, White, e ecify: WHI	etc.
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should bents and Ments armarked umetic e	HENRY RAY				ADELL	KILLMO	V		
end 2 sho leaith and m 27 is m her traum	19a. Informant's Name/Relationshi			g Address (Street a					Code)
of Hear	20a. Method of Disposition		b. Place of Dispos			Date		on - City or To	wn, State
Page ment ant: if ury o	1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp.		T. HOLLY		1 4 4 4	03/05	ONANG	COCK, V	A
permit. Pages 1 en Depertment of Heal Important: if item 2 eny injury or other ance.	21. Signature of Fureral Sovice L	icensee	22.	Name and Address	ss of Facility				
402.0	23a. Parti. Enter the disease, or o	complications that caused the c	WIL	LIAMS FUNE	RAL HOME,	94 MARKET	ST., Of	VANCOCK,	VA 23417 Approximate
	shock, or heart failure. List o	inty one cause on each line.					irrest,		Onset and De
Physician /Medical	disease or condition resulting in death)	Due to (or as a con	relvic Fra	chine with	~ compi				2084
Examiner		Due to (or as a corr	sequence on.						
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of the	9 Unknown	9□ Unknown							
Physician: The law requires thet the death this cartificate has been signed by the atterral director, page 2 should be deteched for ural director, page 2 should by Physician: To Be Completed by Physician	Part II. Other significant condition	s contributing to death but not	resulting in the un	dertying cause give	en in Part I.		tobacco use o	contribute to the	e cause of dea ably 4 ∐Un
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hysic his ce I dire	1 Nes 2 No	22	2 ER/Outpatient		4 Li Nursing F	ome 5 Res	idence 6 🗆	Other (Specify	)
g et o	27. Manner of Death  1 Natural 5 Pending		28b. Time of Injury	28c. Injun Worl		28d. Describe			
Attending or death. ector: Alier by the funer by the funer ification	2 Accident investigation inves	ot be	1300		Yes 2. ☑No	Cought			(Davids March
To the Hospital or Attending Physician: The law within 24 hours effer death.  To the Funeral Director: Affer this certificate has completely filled in by the funeral director, page 2 Medical Certification: To Be Comp	4 Homicide determin	building, etc. (Sp	ne Orveve			City or To	wn, State)	Imber or Rural	Pocarole
To the Hospital or Attendi within 24 hours efter death. To the Funeral Director; A completely filled in by the to Medical Certificati	29a. Certifier 1 Certifying (Check only 2 Medical E	p Physician: To the best of my xaminer: On the basis of exame and manner stated.	knowledge, death nination and/or inv	occurred at the timestigation, in my op	ne, date and place pinion, death occu	, and due to the rred at the time,	cause(s) and date and plac	manner as sta ce, and due to	ated. the cause(s)
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State Registrar	Chnistophen SN, 31. Date filed (Month, Day, Year)	vio completed cause of death ( victex D.O. 100  32. Register's Si  2 2005	PE CARIN	will St.	SAlisbo	iny mo	el.		

State of Maryland / Department of Health and Mental Hygiene 05 For State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) oct 29,2005 Year **Physician** 11:50pm м Schuellein Wilma /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Carriage Hill Nursing Home Bethesda If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🛛 F 91 Director March 6,1914 | Washington DC 219-42-2762 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d, Inside City Limits 10a. State 10b. County 28a-f show other traumatic avant. If e Medical Exaculture rust be nutflied at 1X Yes 2 No MD Bethesda Montgomery Director 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number WIL ō Itams 23a 5626 Lamar RD 20816 United States Pages 1 and 2 should be filed within 72 hours after death a nent of Health and Mental Hygiene. int: If itam 271s marked other than "natural", or Itams 23 Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Own Home 3 Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First, Middle, Last) Be Frank Frederick Dahn Noreen Norris 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Robert Schuellein / Husband 5626 Lamar RD, Bethesda, MD 20816 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State permit. Page Department of Important: If any injury or once. ō Monocacy Cemetery 11/7/05 • 4 □ Donation 5 □ Other (Specify) Beallesville, MD 22. Name and Address of Facility Joseph Gawler's Sons, INC 21. Signature of Funeral Service Licenses The lambel 5130 Wisconsin Ave, N.W. Washington DC 20016 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Years Immediate Cause (Final disease or condition resulting in death) Hypertensive Cardiovascular Disease Enysician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year ŏ in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by Cerebral Vascular Accident 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2 No Division of Vital To the Hospital or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 M Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No P this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27, Manner of Death Certification: 1XXVatural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Diractor: d in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To tha Funaral I 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier ical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MD0013187 November 1, 2005 Der 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. Neill Kennedy, MD 5530 Wisconsin Ave., Chevy Chase, MD #32. Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 0 4 2005 Registrar

Amend item#26, perverbal, C849, 11/22/05 TI
State of Maryland / Department of Health and Mental Hygiene 15 For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 1:50 BW **SHANDEJ** とったりつって 10 31 2002 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Bethesda, Suburban Hospilal Montgomer | I Under 1 Year | II Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Dec . 20 , 1929 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral X**□M 2□F Yrs. 219-29-5323 75 Iran Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itema 23a or 28a-f show any injuty or other traumatic event, tra Madical Examinat must be motified. 1 Yes 2 No Md. Montgomery Bethesda Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20816 5009 Newport Ave Iran Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. ☐Yes 2√ No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: White Year or Dates: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Civil Servant Govt. of Iran 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sughra Sharafi Yadullah Sharafi 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pirooz Sharafi - Son 5009 Newport Ave, Bethesda, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Parklawn Cemetery 11-3-05 Rockville, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Universal II Mortuary Inc. of Funeral Service Licensee Signatu 411 Kennedy St, N.W., Wash, D.C. 20011 rt1. Enter the disease, or complications that shock, or heart failure. List only one caus sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest each line. Interval Between Onset and Death Immediate Cause (Final disease or condition Due to (or as a consequence of): Physician concer resulting in death) /Medical **Examiner** Sequentially list conditions, flary, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dub to (or as a consequence of): Examine Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: WA 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 3 Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 Other (specify) Vital Records, P.O. been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Ves 2 No 3 Probably 4 Unknown 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 1 ☐ Yes 2 1 No certificate 1 ☐ Yes 2 ☑ No 25. Was case relerred to medical examiner? Be 26. Place of Death (Check only one) director Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2XXER/Outpatient 3 □ DOA ပ္ 1 Yes 2 No 6 this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: After Division Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 □ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) determined 4 - Homicide 6 within 24 hours a To the Funeral C Hospite 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and tyle of certified 2 DO 55480 30. Name and address of person w completed cause of death (Item 23a) (Type, Print) CARMODY BRENDAN 8600 Old Georgetown Rd, Bethesda, Md. 20814 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 04 2005 NOV Registrar

State of Maryland / Department of Health and Mental Hygiene 15 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Physician ам Albert John Sambucc November 2, 2005 8:19 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery 8. Date of Birth (Month, Day, Year) Nov. 24, 1 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 New York 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days Hours 12XM 2□ F 063-24-1965 75 Yrs 1929 Director Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits in then "neturel", or Items 23a or 28e-f show The Modical Exposition pust be notified at 1 TYes 2X No Maryland Montgomery Silver Spring Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death Funeral 13111 Mica Court 20904 USA 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status hours after 1 Never Married 2 Married 1 XYes 2 ☐ No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1947 - 51 1 ☐ Yes 2 ☑ No Specify Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15 Decedent's Education 16a. Decedent's Usual Decupation filed within 72 (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "ne any injury or other treumeric. (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Engineer Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James P. Sambuco Lena I. Spalita 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13111 Mica Court, Silver Spring, MD 20904 of Disposition (Name of Date 7 20c. Location - City or Town, State Antonina P. Sambuco/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition November 7 1 DeBurial 2 Cremation 3 Removal from State Gate of Heaven Cemetery 2005 \* 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, Maryland 21. Signature of Funeral Service Licensee Francis dogs of Tins Funeral Home Inc 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) a. Pneumonia /Medical Due to (or as a consequence of) **Examiner** Cardiac Arrhythmia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner death certificate be executed attending physician and for use as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760 Physician/Medical as the IF FEMALE esn 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ pe 1 Yes 2 XNo 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No certificate 1 Yes Hospitel or Attending Physicien: rector. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 No 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification; To this funeral dir 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending Injury s after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide within 24 hours a To the Funerel C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D47928 11/3/05 541 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Georgia Ave #304 MIS Bohador 10301 Lila 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

10 Sta Registrar

•	1 - For State/MFND#25per/MF11/8 Registrar AMT1U#23a(a-d)	State of Ma 05, FW, MOC	aryland / [	Departme <i>Certifica</i>	nt of H	ealth a	and Me	ental Hy	/giene	000	)	37743
	1. Decedent's Name (First, Middle, Last		D,HW,MOO	001111100				2. Date of De				3. Time of Death
	JOSEPH JACQUES	SCHETTEW	'I					Month Octobe	r 2		өаr 05	12:14 A <sup>M</sup>
ı	4a. Facility Name (If not institution, give	street and number)	<u></u>	4b. Cit	y, Town, or	Location of	_			County of		
	Suburban Hospital			Ве	thesd	a			Mo	ntgom	ery	,
	Social Security Number     6. Se		e (In yrs. last bin	Month:	er 1 Year S Days	If Under	24 Hrs. Min.	8. Date of Bi (Month, D	rth av. Year)	9.	. Birth	place (State or Foreign
	218-30-6662	3kM 2□ F	83	Yrs.	Julys	110013		Jan 21		22 C		o, Eygpt
}	Usuel Residence of Decedent  10a. State 10b. County		10c. City, Town	n or Location								10d. Inside City Limits
			loc. Oity, Town	IT OF EGGALION								1 ☐ Yes 2√2 No
1	MD Montgom	ery	Potomac	404.7	. O. d.				10 - 0'''			
	10e. Street and Number			101. 2	ip Code				iug. Citi	zen of Wha	It Cou	nury r
-	11612 Deborah Driv	e 12. Was Decedent	Eugrip II C	13. Was Dec		854	ain? /Cno			ed Sta		s of Ameri
	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?		If Yes, sp	ecify Cuba	n, Mexican	, Puerto F	lican, etc.)	0-	Black,		
١.	3 □ Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes	2 <b>X</b> No	Specify:				Specify:	Ca	ucasian
	15. Decedent's Edu		16a.	Decedent's Us	ual Occupa	ation			16b. Ki	nd of Busin	iess/Ir	ndustry
	(Specify only highest grad	de completed) College (1-4or 5	54)	(Give kind of v life. DO NOT	vork done d use retired	luring mos	t of workin	g				
	Clotheritary/Secondary (0-12)	5+		inancia	1 Off	icer			Un:	ited 1	Nat	ions
	17. Father's Name (First, Middle, Last)					18. Mothe	r's Name	(First, Middle	e, Maiden	Sumame)		
	Jacques Schettewi					Math	ilde	Menas	ce			
	19a. Informant's Name/Relationship (T)	ype, Print)	19b	. Mailing Addre	ss (Street a	and Numbe	or or Rural	Route Numb	per, City o	r Town, Sta	ite, Zij	o Code)
	Fortunee Schettewi	, Spouse	11	1612 De	borah	Driv	e Pot	tomac	MD 20	0854		
Î	20a. Method of Disposition		20b. Place of	Disposition (Nature), crematory of	ame of	1000		ite		cation - Cit	y or To	own, State
Į	1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donati∮n /5 ☐ Other (Specify)			n Memor	-	1	10-31	1-2005	01ne	MI	)	
	21. Signature of Fineral Service Licens	:00										Home, Inc
												, MD 20904
	shock, or heer failure. List only o Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as b. End Sta Due to (or as Diabetes c. Coronar Due to (or as	a consequence ge Renal a consequence Mellit	of):  L Disea: of): Us V Disea: of):	se		M	-0151	. Y.			
4.7	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetel death	3 ☐ Ectopic 5 ☐ Other (					4	23d. Date o Month		ery Day Year
	Part II. Other significant conditions co Respiratory Fai	_	ut not resulting in	n the underlying	cause give	n in Part I.			tobacco u Yes 2[		ite to ti	he cause of death?
								24a. Was		24b. Wer	e auto	opsy findings available
1		<u> </u>							òrmed?	prio	r to co th?	impletion of cause of
1	25. Was case referred to medical					26 Place	of Death	1 ☐ Yes	2 🖾 No	1	105	2□ No
	examiner?	Hospital: 1 🎦 Inpatie	ent 2 ER/Ou	itpatient 3 🗆 🛭	Othe			e 5 Res		S Dobor /	Sacr	fr.)
	27. Manner of Death 1 ≦Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Da		Time of njury	28c. Injury Work		21	8d. Describe			Specii	y)
	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inj building, et	ury - At home, fa c. (Specify)	rm, street, facto	ory, office		21	8f. Location City or To	(Street and own, State	d Number o	or Rura	al Route Number,
	29a. Certifier 1	rsician: To the best iner: On the basis of and manner sta	f examination an	dor investigation	d at the tim on, in my op	e, date an pinion, dea	d place, ar th occurre	nd due to the d at the time,	cause(s) , date and	and manne place, and	∍r as s due t	stated. o the cause(s)
	29b. Signature and title of certifier			2	9c. License	number			29d. Dat	e signed (A	Aonth,	Day, Year)
	homes	U. J.	12801	I	000473	330		(	Octob	er 29	, 2	2005
	30. Name and address of person who co		,	(Type, Print)								
	Thomas V. Joseph,				rive I	Rockir	i11a	MD 200	252			
	31. Date filed (Month, Day, Year)		ar's Signature			- V - CLV		.u//.				
	1000 0 7 2	1005	12 /3	Morte	1							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** Month Year 12:10 P M Joyce T. Scruggs November 2, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 11407 Rolling House Road Rockville Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□ M 21 F Director 579-46-1927 69 Yrs 25, 1936 New Jersey Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. Count 10d. Inside City Limits itam 27 is marked other than "natural", or Itams 23a or 28a-f show other traumatic evant, the Modical Evantice must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11407 Rolling House Road permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene Important: If itam 27 is marked other than "naturat", or Itams 23s any injury or other traumatic event, tra Medical Evantiver must any injury or other traumatic event, tra Medical Evantiver must 20852 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No White ģ Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edwin D. Tomaloe Claire Marie Sattler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Henry C. Scruggs/Husband 11407 Rolling House Road, Rockville, MD 20852 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) November 7, Gate of Heaven Cemetery 2005 Silver Spring, Maryland 21. Signature of Funeral Service License Francis J. Collins Funeral Home Inc Annewariefarker 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Atherosolerotic /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed the burial-transit and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 the attending physician Physiclan/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Year Month Dav signed by the at d be detached for 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3-em0 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' certificate 2X No 1 ☐ Yes 2 No 1 Yes I or Attanding Physician: after death. 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 esidence 6 Other (Specify) 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27 Manner of Death 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital within 24 hours a To the Funaral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 20 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 0 Registrar 2005

			For State Registrar		State of	Marylan		artmen tificate				ental Hyg	iene g. No.	05	37745
2		#	1. Decedent's Name (First, Middl	e, Last)								<ol><li>Date of Deat Month</li></ol>	Day,	Year	3. Time of Death
	Physicia /Medic	al	Louise		ae		tottle					Vovember		2005	08:10 AM
	Examin		4a. Facility Name (If not institution	n, give str	eet and numb	ver)		4b. City,	Town, or	Location	of Death.		4c. C	county of Death	
		· 电	Washington Cou					Hage			2.11			shingto	
	Funeral Director		5. Social Security Number 173–03–2756	6. Sex 1 □ N	7. A 2187 F	Age (In yrs.	/ast birthday) Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Birth (Month, Day, Sept.27	Year) <b>,19</b> 1	9. Birth Cou	place (State or Foreign ntry) I <b>sylvania</b>
	pu k		Usual Residence of Decedent  10a. State 10b. County			10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
	sho	ក													1 Yes 2 No
	the N	Director	Maryland Washin  10e. Street and Number	gton			Boonsb	0 <b>ro</b> 10f. Zip	Code			1	0g. Citiz	en of What Cou	intry?
	with so or	ā	141 South Main	Ctro	o.t			2	1713					USA	
	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28e-f show or other traumatic event, the Musical Exantral restriction.	Funerai	11. Marital Status		. Was Deced		.S. 13.				igin? (Spec	cify Yes or No- Rican, etc.)		4. Race · Amer	
	r Hend	F	1 Never Married 2 Mar	ried	Armed Force 1 ☐ Yes 2							Rican, etc.)		Black, White	
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an	2 sho and Is my		19a. Informant's Name/Relations									Route Number		Town, State, Z.	ip Code)
Σ	1 and 2 Health tem 27		David Stottlemy	er/S	on				A	Thur		MD 217			0
ore	of He		20a. Method of Disposition  1   Burial 2 □ Cremation	3 ∏Be	moval from SI		Place of Dispo cemetery, cre	natory or c	me of other plac	<b>a</b> )	וט	ate	20c. L <i>o</i> c	ation - City or 1	own, State
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Baltimore,	permit. Pages 1 an Department of Heali Important: If Item 2 eny injury or other 2008.		21. Signature of Funeral Service	Ligenses								auffer			-
0	80 = 5 8		23a. Part1. Enter the disease, of	10C	le							Thurmo		MD 2178	Approximate
	Physician /Medical Examiner  per per per per per per per per per per	Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	<b>a</b> . b.	Due to (o	r as a consec // S/S r/as a consec			:10	cata	nwi	phe			
Ć,	exec n an	Exa	resulting in death) Last	0.	Due to	s a consec		. 11.							
8760,	ate be executed hysician and the burial-transit	dical		d.		Kini	el in	uffe	ung	1 .					
89	ificat g phy as the	edi		2-6561				//	-6						
P.O. Box	that the death certific ed by the attending p detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23		th 2∏Feta nt at time ot o	al death 3[	⊒Ectopic p ⊒ Other (s)					2	3d. Date <i>o</i> f deli M <i>o</i> nth	very Day Year
Ś	es Ded	þ	Part II. Other significant condit	ions cont	nbuting to dea	ath but not res	sulting in the u	inderlying (	cause giv	en in Part	l.		bacco us es 2		the cause of death?
ÿ	v requir been si should	Completed								-		24a. Was	.n	24b. Were au	topsy findings available
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LO	ding h. After fune	Floor	1 Dentural 5 Pend	ing tigation	(Month	i, Day Year)	Injury	м		k? Yes 2 [	]No				
Division	or Attending Pater death. I Director: After I din by the funera	Certification:	3 ☐ Suicide 6 ☐ Could	-	28e, Place	of Injury - At I	nome, farm, si	reet, factor	rv. office		2				ral Route Number,
<u>&gt;</u>	after Direction by	erti	4 Homicide	Milleu	buildin	g, etc. (Speci	ify)					City or Tow	n, State)		
_	Hospita 4 hours Funeral	Medical Co			er: On the ba							and due to the ded at the time, d			stated. to the cause(s)
	To the To the complet	₹ Ø	29b. Signature and title of certif	ier	(M)			29	c. Licens	e number			29d. Date	e signed (Monti	n, Day, Year)
	ŏ d ≳ d		•		TOP	-			Dog	622	23		11	14105	
•			30. Name and address of person	n who cor	npleted cause	of death (Ite	om 23a) (Type					HAGEL.	1782	111 de 111	) .
27	St	ate	31. Date filed (Month, Day, Yea	r)		gistrar's Sign	nature					.,,,			

			1 - For State Registrar	State of Maryland		artment of Hartificate of			gieße	5 3	37746
	\$100p.		Decedent's Name (First, Middle, Last)					2. Date of De	aath	Vons	3. Time of Death
	Physici /Medic	_	Robert Moyers Shac	ckelford				NOVEM	BER 3. 2	905 005	4:10 P <sup>M</sup>
AL OF	Examin		4a. Fecility Name (If not institution, give s			4b. City, Town, o	r Location of Dea	ath	4c. County	of Death	
	A-66 1 1	(4)	4306 BURKITTSVILI  5. Social Security Number 6. Sex		ast highday)	KNOXVII	LE If Under 24 Hr	s. 8. Date of Bir		ERICK	
	Funeral Director			M 2□F 61	Yrs.	Months Days	Hours Mir		ay, Year)	Mary.	ace (State or Foreign try)
	D		Usual Residence of Decedent					OCCODEL	2,1777		
	anylan show	<u> </u>	10a. State 10b. County		r, Town or Lo					10	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
	28a-f	Director	Maryland Frederick	KI	oxvil]	10f. Zip Code			10g. Citizen of \	Albeit Count	
	with the party	i	4306 Burkettsville	Road					U.S.A.	What Count	ıy:
	ns 23	era		12. Was Decedent Ever in U. Armed Forces?	S. 13.1	21758 Was Decedent of F	lispanic Origin? (	Specify Yes or No	o- 14. Rac	e - America	
ထ္	or ite	by Funeral	1 Never Married 2 ☐ Married	AmeerForces? 1 ☑ Yes 2 ☐ No If Yes, Give		f Yes, specify Cubin		nto Hican, etc.)		ck, White, e	itc.
003	within 72 hours after death with the Maryland ene. then "natural", or items 23a or 28a-f ehow the Mardigal Exeminer must be notified at	d by	3 Widowed 4 Divorced	Year or Dates:					Specify	Wnl	
21215-0036	n 72 t	Completed	15. Decedent's Educ (Specify only highest grade	cation completed)	16a. Deced (Give	ient's Usual Occup kind of work done DO NOT use retire	oation during most of wi d)	orking	16b. Kind of Bi	usiness/Ind	ustry
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ğ	e filec al Hyg othe vent,	Be C	17. Father's Name (First, Middle, Last)	-1161				ame (First, Middle		ne)	
<u>Na</u>	Menta	To E	Allen Franklin Sha	ckellord			Berth	a Cooley			
Maryland	2 sh and ls m	in i	19a. Informant's Name/Relationship (Ty) Sylvia Mullenix -			ng Address <i>(Street</i> Kaitzel					
e,	1 and Health em 27 ther t	ļ ļ	20a. Method of Disposition			sition (Name of	Road, Kii	Date	20c. Location -		L758 wn. State
nor	ages ont of it: If it y or o		1 ☑Burial 2 ☐ Cremation 3 ☐R 4 ☐ Donation 5 ☐ Other (Specify)			natory or other pla le Cemet		8-2005			Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28a-f ehow empty or other traumatic event, the Madical Examinating the notified at ance.	1	21. Signature of Funeral Service License			. Name and Addre				-	naryrand
ä	Per in Per		Sharow Cany	elle Colle							and 21716
	*		23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on	cations that caused the death	n. Do not ent	er the mode of dyii	ng, such as cardi	ac or respiratory a	rrest,		Approximate Interval Between
, 1	Physician		Immediate Cause (Final disease or condition	Hypertensive	_ athe	rosclero ti	ic Condi	ovusuda	n dise	ise	Onset and Death
25	/Medical Examiner		resulting in death)	Due to (or as a consequ	uence of):						
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Вох	The law requires that the death certific ele has been signed by the attending p page 2 should be detached for use as	Physician/Me	in the past 12 months?	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3	Ectopic pregnance Other (specify)	у			te of deliver nth	ry Day Year
P. O.	the d	ysk	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown	Jan. 5 _						
٥.	res that igned b be deta	by Pl	Part II. Other significant conditions con	ntributing to death but not resu	ulting in the u	nderlying cause giv	ven in Part I.	23e. Did	tobacco use cont	ribute to the	e cause of death?
rds	w require been sig should b	edt						1 🗆	Yes 2□No	3 Proba	ably 4 Unknown
ecc	e law requ has been ye 2 shouk	Completed						24a. Was	DSV I	orior to com	osy findings available apletion of cause of
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Vita	ician: Th certificete rector, pag	Be	25. Was case referred to medical examiner?	lospital:		_ lott	100	eath Check only			
ō	Phys r this ral dii	To	1 X Yes 2 No '' 27. Manner of Death	1 inpatient 2	ER/Outpatier 28b. Time of	I 3LI DOM	4   Nursing	Home 5 Resi	how injury occur		SCENE
ion	nding tth. :: Afte e fune	atior	1 SNatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	Injury		rk?  Yes 2 □No		. ,		
Division of Vital Records,	er des	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify	me, farm, str	eet, factory, office			Street and Numb	er or Rural	Route Number,
٥	Ital or irs aft ral Di			,							
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifior completely filled in by the funeral director,	edical	29a. Certifier 1 Certifying Phys (Check only 2 Medical Examination)	sician: To the best of my kno- ner: On the basis of examinal and manner stated.	wledge, deatl tion and/or in	n occurred at the til vestigation, in my o	me, date and place prinion, death occ	ce, and due to the curred at the time,	cause(s) and ma date and place,	inner as sta and due to	ited. the cause(s)
	To th To th comp	Me	29b. Signature and title of certifier			29c. Licens	se number		29d. Date signe	d (Month, E	Jay, Year)
	0		I MAN,	mis		0 (	СМЕ		NOVEMBE	ER 4,	2005
1	SALLY		30. Name and address of person who co				Com Tarrow	DATEMAN	DE MARY	7T A 3 TT	01001
			1 Date filed (Meeth Day, Year)	Registrar's Signa		111 PENN	STREET,	BALTIMO	KE, MARY	AND,	21201
	Sta Registi		31. Date filed (NOV av Yar) 2005	Registrar's Signa	400	de					

Amend Item 25 per Dr., G852, U2/10/06dbb Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Wilfred Cole Shilke 30, 2005 October 10:50 p<sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Carroll Lutheran Village Westminster 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 □ F Min. 216-12-8008 Yrs 89 Director Aug 13, 1916 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show treumatic event. The Medical Examinar must be notified at 1 Yes 2 No Director Hampstead Maryland Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 238 1026 Highfield Drive 21074 USA e filed within 72 hours after death is all Hygiene. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: white þ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing Welder 6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 is marked oth any lipiry or other treumatic event sons. Be George W. Shilke Rebecca Dickmyer ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Sprinkle, sister 4011 Dana Court, Hampstead, MD 21074 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Evergreen Memorial 11/03/2005 Finksburg, MD \*4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Eline Funeral Home 934 South Main St, Hampstead, MD 21074 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical **Examiner** unay bladda nostate aud Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit Due to (or as a consequence of): attending physiclan Division of Vital Records, P.O. Box 68760 Physician/Medical as the l IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an this certificate has autopsy performed? 1 Yes 2 LHO Hospitel or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Desiring Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred Certification; After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 3 🗌 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Thomicide 24 hours 1 🕩 cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title -0054218 10-31-05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ralandor, West minita MD 211577 Registral Signature B 31. Date filed (Month, Day NOW) State Registrar

Please Type or Print in Black Indelible Ink

		1 - For State Registrar		Maryland / Dep	partment of prtificate of	Health and f Death	Mental Hy	giene	15 (	37748
Physici	an	Decedent's Name (First, Middle	e, Last)				2. Date of De Month	eath Day	Year	3. Time of Death
/Medic	cal	Peggy 4a. Facility Name (If not institution	Tyndall	Stur			10	24	05	2310 M
Examin	er					, or Locetion of Dea	atn		ity of Death	
Funeral	54.000	Peninsula Regio  5. Social Security Number	6. Sex 7.	Age (In yrs. last birthda	Salisi y) If Under 1 Yea	r If Under 24 Hr.		th	Omico 9 Birthr	place (State or Foreign
Director		218-20-9504	1□M 2 <b>X</b> F	79 Yrs.	Months Days	s Hours Mir	03-22-			land
and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location					10d. Inside City Limits
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h the	Director	MD Wicomi	co	Salisbu	10f. Zip Code			10g. Citizen of	f What Cour	ntry?
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90 L	Funerai	11. Marital Status	12. Was Decede Armed Force	ss?	. Was Decedent of If Yes, specify Cu		Specify Yes or No rto Rican, etc.)	- 14. Ra	ace - Americ ack, White,	
2/8	by F	1 Never Married 2 Marr	ied 1 🗀 Yes 2 If Yes, Give Year or Date	No	1 ☐ Yes 2 X No			Spec		
2/3 5-0036 72 hours ath natural, or		15. Deceden	t's Education	16a. Dec	edent's Usual Occu	upation		16b. Kind of	Whi	
21215-0 21215-0 1 within 72 hu iene. 1 then "netu	Completed	(Specify only highes Elementary/Secondary (0-12)	st grade completed)  College (1-4c	(Giv	re kind of work done DO NOT use retire	e during most of wo	orking			3001.9
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and and the file of other ovent,	Be	17. Father's Name (First, Middle,	Last)				ame (First, Middle		ітө)	
Marylanc de should be if it and Mental H. 7.1 is marked of traumatic ever	7	Ernest Tyndall  19a. Informant's Name/Relations	hin (Tyne Print)	19b Ma	iling Address (Stree		Jackson		- C 7'-	0.44
		Paul Sturgis/S			29 Mt. Ve					
Ore, M	ľ	20a. Method of Disposition		20b. Place of Dis	position (Name of ematory or other pla	ace)	Date	20c. Location		
Stugis  Baltimore, Normit. Pages 1 and Department of Health moortant: If item 27 and injury or other transcen		1 □ Burial 2 ②Cremation 4 □ Donation 5 □ Other (S		110	y Cremato		7/2005	Salishu	rv. M	arvland
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m 205 9 9	7	AN KLOWY XH	MMass.	M00295 1	1673 Some	erset Ave	Princ	ess Ann	e, MD	21853
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Geath death e atte	icia	in the past 12 months?	4 Pregnant	at time of death 5	□Ectopic pregnanc □ Other (specify) _	cy				Day Year
Division of Vital Records, P.O. after a death.  I or Attending Physician: The law requires that the diater death.  Director: After this certificate has been signed by the in by the funeral director, page 2 should be detached.	hys	9 Unknown	9 Unknown							
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Sior •ndir •ath. or: Af	atic	Natural 5 Pending investig	ation	say , oar) inquiy		Yes 2 No				
or Att	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 286. Place of I	Injury - At home, farm, s etc. <i>(Specify)</i>	treet, factory, office		28f. Location (S City or Tox		ber or Rura	l Route Number,
Division of Vital Rewither Hospital or Attending Physician: The Within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page		29a. Certifier 1 Certifyin	a Physician: To the he	at of my translation dec	als al als al					
e Hos 24 h Fun e Fun	Medical	(Check only 2   Medical I	Examiner: On the basis and manner	st of my knowledge, dea or examination and/or i stated.	nvestigation, in my	opinion, death occu	e, and due to the ourred at the time,	cause(s) and m date and place,	anner as sta and due to	ated. the cause(s)
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certificat within 24 hours after death. Within 24 hours after death. Completely filled in by the funeral director, page 2 should be detached for use as the	Me	29b. Signature and title of certifier	. /			se number		29d. Date signe	ed (Month, L	Day, Year)
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		30. Name and ddres of person	who completed cause of	f death (Item 23a) (Type	, Print)	n0 0	10.50	00000	2	NO CO
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend 1 tem 2 per doc 850 12-1-05 vt
State of Maryland / Department of Health and Mental Hygiene 0 5 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November 15, Year **Physician** 9:00 A Chris George Samaras 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 925 Bay Ridge Rd. Annapolis Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F Vre 83 11-8-1922 Director 233-30-7360 Maryland Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State Show r then "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Directo Annapolis Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 925 Bay Ridge Rd 21403 death USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White etc. within 72 hours after TYPYes 2 No If Yes, Give Year or Dates 1943-46 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: ģ White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Owner/ Operator Liquor Store 12th i. Pages 1 and 2 should be filed witnest of Health and Mental Hygie stant: If Item 27 is marked other tigury or other traumatic event, In 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George Samaras Daphne Platis ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary K. Samaras/ Wife 925 Bay Ridge Rd., Annapolis, Maryland 21403 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Depertment of Important: If eny injury or once. St. Demetrios Cem. 11-18-05 4 ☐ Donation 5 ☐ Other (Specify) Annapolis, Maryland 21. Signal Funeral Solvice Licensee 22. Name and Address of Facility George P. Kalas Funeral Home Inul "Eller 2973 Solomons Island Road, Edgewater, Md. 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MYD CARDIAL /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Dua to (or as a consequence of). Examine physicien and s the burial-transit or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical as attending for use as IF FEMALE: 23c. ff yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the a should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, D130036 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? SMOWNA 24a. Was an certificate has t performed? 1 ☐ Yes 2010 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home \$\text{\text{X}}\text{Residence} 6 ☐ Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 Natural 5 Pending death. investigation 1 Yes 2 No Director: 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours efter or To the Funeral Direct completely filled in by 4 - Homicide the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 1) (Type, Print)
116 Reference Huy, Svert 400 Annipour 2149 MO

State Registrar

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31. Date filed (Month, Day,

30. Name and addre is of pers in who completed cause of death (Item 23a) (Type, Print)

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			1 - For State Registrar	State of Marylan		artment o			Mental Hy	ygien Reg. Ti		5 3	7750
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036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other then "natural", or iteme 23a or 28a-f show important: if item 27 is marked other then "natural", or iteme 23a or 28a-f show projuly or other treumatic event, the Madical Exeminer must be nutilied at ONCE.	Completed by Funeral Director	11. Marital Status  1 Never Married 2 A Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? Wor 1 12 Yes 2 12 No 1f Yes, Give War Year or Dates:	Id 13.	Was Deceden If Yes, specify 1 ☐ Yes 20	Cuban,	anic Origin? Mexican, Pu Specity:	(Specify Yes or Nerto Rican, etc.)	10-		e - America k, White, e	
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	/Medic Examin	or I	4a. Facility Name (If not institution, give street and number) RT. 27 SOUTH OF KATE WAGNER ROAD			4b. City, Town, or Location of Death WESTMINSTER			4c. County of Death CARROLL					
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K	2/17		30. Name and address of person who	completed cause of	death (Iten	n 23a) (Type	, Print) $1\overline{1}\overline{1}$	Penn S	treet	Balti	more,	Mary	land	21201
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State Registrar

	For	ent of Health and Mental Hygiene 05 37753
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Physician /Medical		November 03 2005 610 PM
Examiner	4- F	City, Town, or Location of Death  4c. County of Death
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IMOre, Pages 1 an nent of Hea int: If itam ury or otha	20a. Method of Disposition  20b. Place of Disposition (  20c. Place of Disposition (  20c. cemetery, crematory)	or other place)
Lim Pag tant: jury o		Lima Cem. 11-9-2005 Chesapeake City, MD
Baltimore, permit. Pages 1 at Department of Hea Important: if itam any injury or otha	21. Signature of Funeral Service 22. Name R. T.	o and Address of Facility Foard Funeral Home, P.A. George Street, Chesapeake City, MD 21915
	23a. Part1. Enter the alsease, or complications that caused the death. Do not enter the r shock, or head ailure. List only one cause on each line	mode of dying, such as cardiac or respiratory arrest,  Approximate Interval Between
Physician	Immediate Cause (Final	Onset and Death
/Medical	disease or condition resulting in death)  Due to (or as a consequence of):	12
Y Examiner	Sequentially list conditions. b. H7V	AD
P #	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	
58760, licate be executed physician and s the burial-transit	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):	
8760, cate be exported the burial		G-DUP
S87 icate phys	5	
OX 6	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23d. Date of delivery
S. Bo. Beath death death of for u	230. Was decedent pregnant  1 □ Live birth 2 □ Fetal death 3 □ Ectopi  in the past 12 months?  4 □ Pregnant at time of death 5 □ Other	oic pregnancy Month Day Year or (specify)
the o	9 Unknown	
ords, P.O	Part II. Other significant conditions contributing to death but not resulting in the underlying	
rds quire an sig		1 M Yes 2 No 3 Probably 4 Unknown
Record Record he law requir		24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of
The The page	E O	performed? death? 1 ☐ Yes 2 █ No 1 ☐ Yes 2 ☐ No
Vital Sician: 1 sician: 1 certificat irector, p	25. Was case referred to medical     examiner?	26. Place of Death (Check only one)
of Vita Of Nita Physician:	O 1 ☐ Yes 2 📉 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐	DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)
ing P	27. Manner of Death  28a. Date of Injury (Month, Day Year)  28b. Time of Injury Injury	28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No
islon witanding death. ctor: After y the fune	2 Accident investigation  2 Solicide 6 Could not be continued as Place of Injury - At home, farm, street, far	
DIVISION Of 10 OF Attention of after death.  Director: Attent this in by the funeral director in the funeral director.	27. Manner of Death  1 X Natural 2 Accident 3 Suicide 4 Homicide  28a. Date of Injury (Month, Day Year)  28b. Place of Injury - At home, farm, street, fare building, etc. (Specify)	City or Town, State)
ris ital		urred at the time, date and place, and due to the cause(s) and manner as stated.
a Ho 24 h a Fur letely	29a. Certifier (Check only one)  29h. Signature and title of certifier  29h. Signature and title of certifier	lation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
To tha within 2 To tha comple	29b. Signature and title of certifie	29c. License number 29d. Date signed (Month, Day, Year)
		D0062903 11/04/05
2.	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	
7		ure de Grace, MD 21078
Stat	te 31. Date filed (Month, Day, Year) 32. Registrar's Signature	
Registra	NOV 0 7 2005 Beau & Spelle	

State of Maryland / Department of Health and Mental Hygiepe 05 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Jean Tisdale November 2005 5:25 Vivian /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Memorial Hospital Frederick Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 21, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2√□ F 72 Yrs 1933 Montana 517-34-1425 June Director Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Nadical Examinant must be notified at 1 ☐ Yes 2 ☐ No Maryland | Frederick Thurmont Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 120 Catoctin Avenue 21788 U.S.A. Funerai permit. Pages 1 and 2 should be filed within 72 hours after dea. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or the any injury or other traumatic even. 12. Was Decedent Ever in U.S. Amed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: à 3 XWidowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Printer Gateway Printing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William A. Powell Barbara Hattie Lubbers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20886 19a. Informant's Name/Relationship (Type, Print) Teressa Tisdale/Daughter 18800 Walkers Choice Rd. #3, Montgomery Village MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Smithsburg Crematory 11/8/2005 Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fureral Service Licen ROBERT E. DAILEY & SON FUNERAL HOMES, 23a. Parti. Enter th disease, or complications the shock, or heart fall in ... List only one cause of 615 EAST MAIN SIKEET, THURMONT, MD 21788 Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) myocordial Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physicien and the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical use as t IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Dale of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Year Month Day 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ COP 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has aulopsy performed? Yes 2.25.No certificate ha 2 No 1 Yes 1 ☐ Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No Inpatient 2 ER/Outpatient 3 DOA After this Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ho-completed cause of death (Item 23a) (Type, Print) GILSON MD Date filed (Month, Day, Year) Registrar's Signature State NOV 0 8 2005 Registrar

State of Maryland / Department of Health and Mental Hygieße 1 15 State
Registrar Amend #5 per/fh 11/10/2005 committee of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day November 6 Physician Tibbs 2005 4:20 Lucretia Faye /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Frederick Frederick Frederick Memorial Hospital Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Dec. 30, 1942 7. Age (In yrs. last birthday) 6. Sex Social Security Number **Funeral** Min. Months Days 1□M 2X F Hours Yrs. 62 Dec. Maryland Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b County 77 is marked other than "natural", or items 23a or 28a-f ehow traumatic event, the Modical Examiner must be notified at 1X Yes 2 No Directo Maryland Frederick Frederick 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Numbe 422 West Patrick Street 21701 Funera filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: Completed by 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 10 Housekeeper Nursing Care Facility 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be fil tment of Health and Mental H tant: If item 27 is marked ott jury or other traumatic ever Nellie Mae Shaffer Melvin Hanson Hooper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5401 Village Court, Adamstown, Maryland 21710 Morris Hooper, son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) St. Pauls Lutheran Cem. 11/9/2005 Jefferson, Maryland 22. Name and Address of Facility Keeney and Basford Funeral Home 21. Signature of Funeral Service Licenspe M00999 106 East Church Street, Frederick, Maryland 23a. Part I. Entire the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximale Interval Between Onset and Death Immediate Cause (Final aspiration **Physician** phlumonia days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner + obstructing esophoseal netastate Carunoma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Completed by Physiclan/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 Other (specify) the t Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were aulopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an was an autopsy performed?
Yes 2 7,No 1 Yes of Vital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Medical Certification; To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 VInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident Division 5 Pending 1 ☐ Yes 2 ☐ No death. investigation Director 6 Could not be 3 T Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation in examination death 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Kathleen W Stein MS D32073 6/05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kathleen W. Stern, MD, 810 Ninth Avenue, Brunswick, Maryland 21716-1828 31. Date filed (Month, State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 1 5 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Physician 8:30 P M October 31 2005 Urbaniak /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Cecil 20 Loveland Drive Elkton If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Days Months Hours 1 □ M 2 🕱 F 79 Vrs July 7, 1926 217-20-0971 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location with the Maryland 10b. County 28a-f show the Medical Examiner roust be notified at 1 ☐ Yes 2 X No Elkton Cecil Directo 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 5 21921 or Itame 23a 20 Loveland Drive Funeral filed within 72 hours after death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 (1) No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specity: White Completed by 3 Widowed 4 Divorced "natural". 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Josephine Jankowiak Paul Czawlytko 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Francis Urbaniak/husband 20 Loveland Drive, Elkton, MD 21921 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State All Saints Cemetery 11-5-2005 Newark, Delaware \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility R.T. Fourd and Jones, Inc. 199 Work, DE 19711 21. Signature of Funeral Service Licensee 23a-Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 2 MO **Physician** Due to (or as a consequence of): cancer /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed g physicien and as the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months?
1 Yes 2 No jo 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown cate has been sig , page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Division of Vital 25. Was case referred to medical 26. Place of Death Check on one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No 2 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification; After or Attending 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No To the Hospitel or Attendli within 24 hours after death. To the Funerel Director: A investigation 2 Accident filled in by the 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature ddress of person who completed cause of death (Item 23a) (Type, Print) Gregory A. Masters, M.D. 4707 Ogletown-Stanton Road-St. 2200, Newark, DE 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

0 3 2005

**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene 05 1 - For State Ragistra Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Nov. 3, **Physician** 2005 10:15 рм Charles W. Wielgosz /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Michaels Talbot 7841 Pea Neck Rd. 8. Date of Birth 9. Birthplace (State Month, Day) (Sear) 1938 Mary Land If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 100M 2 F Months Days Hours 214-34-7855 67 Yrs. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked othar than "natural", or itams 23a or 28a-f show any injury or other traumatic avent, the Modical Examinar must be notified at ODE. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Nes 2 No Talbot St. Michaels Directo Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21663 USA 7841 Pea Neck Rd. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 DYes 2 No If Yes, Give Year or Dates: 1 Neyer Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify: 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Construction Sales Roofing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Alice Mary Hughes William N. Wielgosz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 30224 Chesnut Ridge Lane, Trappe, MD Julie W. Taylor/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Donation 5 □ Other (Specify) OurLadyofGoodCounselCem 11/7/2005 Secretary, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Curran-Bronwell Funeral Home, P.A. 308 High St., Cambridge, MD 21613 U Part1. Enter the disease, or complication shock, or heart failure. List only one car Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate
Interval Between
Onset and Death
VEAS Immediate Cause (Final mai **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine Cause (Disease or injury requires that the death certificate be executed ed by the attending physician and detached for use as the buriat-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown ete has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed: 2 No 2 **N**O 1 Yes 1 TYAS 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 PResidence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of e Hospital or Attending Pl 24 hours after death. B Funarel Diractor: After ti Certification: 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours at To the Funarel D 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day Year) 0 en address of person who completed cause of death (Item 23a) (Type, Print) Dr. David Smith, 29466 Pintail Dr., Easton, MD 21601 31. Date filed (Month, PAOV) 0 8 2005 Registrar's Signature Registrar

State of Maryland / Department of Health and Mental Hygiepen For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Year 10:04 A JOSEPH TALMADGE WATKINS /Medical NOVEMBER 2005 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death MONTGOMERY HOLY CROSS HOSPITAL SILVER SPRING
If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 X M 2 □ F Yrs 413-22-7740 Director MAY 21 1924 GRACEY, Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location in than "neturel", or items 23a or 28a-f show the Medical Examinar must be notified at 10d. Inside City Limits 1 ☐ Yes 2XXNo MONTGOMERY SILVER SPRING Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 133 CLAYBROOK DRIVE 20902 Funeral UNITED STATES OF AMERICA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after I ∑Yes 2 ☐ No If Yes, Give 1 Never Married 2 X Married 1943-Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: ð Specify: AFRICAN-AMERICAN 3 Widowed 4 Divorced 1946 Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 should be filed w h and Mental Hygier 7 is marked other th MUNICIPAL GOVERNMENT HOUSING INSPECTOR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked any injury or other treumatic ev ADAM WATKINS SALLIE DARDEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOHNNIE S. WATKINS, SPOUSE 133 CLAYBROOK DRIVE, SILVER SPRING, MD 20902 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) MD VETERANS CHELTENHAM 9 11-09-2005 CHELTENHAM, MD 21. Signature of Fun all ce Licensee 22. Name and Address of Facility HINES-RINALDI FUNERAL HOME, INC. 11800 NEW HAMPSHIRE AVENUE, SILVER SPRING, MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** VENTRICULAR FIBRILLATION 5 MINUTES /Medical Due to (or as a consequence of): **Examiner** AORTIC STENOSIS Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last TWO YEARS Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit CORONARY DISEASE TWENTY YEARS Due to (or as a consequence of): Box 68760. attending physician Physiclan/Medical the IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy ρ in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) P.O. the be detached 9 Unknown 9 Unknown þ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4XXUnknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? has certificate 2∏ No 1 Yes 2 🛛 No 1 Tyes Division of Vital To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital:  $1 \square Inpatient 2 \times IEP/Outpatient 3 \square DOA$ Other: 2 1 ☐ Yes 2 📉 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification; After 1 X Natural 5 Pending investigation death. 1 🗌 Yes 2 🗌 No 2 Accident Director: in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide within 24 hours a To the Funerel D 1 Coertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D23805 NOVEMBER 3, 2005 MD m 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 DANIEL I. WORONOW, M.D. 1400 FOREST GLEN ROAD, SILVER SPRING, MD 20910 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician November 1,2005 7:00a<sup>M</sup> Harold P. Walls /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** F1kton
If Under 1 Year If Under 24 Hrs. <u>Union Hospital</u> 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 ★M 2 🗆 F Yrs Director 236-58-4237 66 March 15, 1939 WV Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits item 27 is marked other then "natural", or items 23a or 28a-f show other treumatic event, the Medical Examinar must be notified at 1 ☐Yes 2 No Director MD Cecil Elkton 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21921 2095 Old Field Point Rd. U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ Specify: White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Industrial 12 Machine Operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be: Department of Health and Mental I Importent: If item 27 is marked of Herbert C. Walls Frances Moore 19a Informant's Name/Relationship (Type Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elijah S. Walls/Son 38 Dogwood Rd., Elkton, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State injury or November 4 ☐ Donation 5 ☐ Other (Specify) Gilpin Manor Elkton, MD 2005 Service Licensee 22. Name and Address of Facility anyi Andrew G. Gee Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21221<sub>ximate</sub> MD Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician NOO Voknown /Medical Due to (or as a consequence of): **Examiner** Unknow Sequentially list conditions Due to for as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last g physicien and Unknow. oronory Due to (or as a consequence of): Box 68760 Physiclan/Medical DOXNO for use as the attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 □Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 4□Pregnant at time of death 5 Other (specify) P.0. be detached signed by Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by 3 Probably 4 Unknown 1 ☐ Yes 2 □ No page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed After this certificate 2□ No 1 Tyes 1 Yes 2 No Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 FR/Outpatient 1 Tyes 2 No 2 3□ DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: the Hospitel or Attending Injury Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A investigation 2 Accident 6 ☐ Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 1 4 Homicide filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D00060756 o completed cause of death (Item 23a) (Type, Print) 30. Name and address of person w Moin Street, MD 21921 Plan 31. Date filed (Month, Day, Year)
NOV 0 4 2005 32. Registrar's Signatur State Registrar

			1 - State Amend Item 2 Registrar Unpend Ite	State of Market 1 per dvr m 23a.27.2	arylar G849 8a-f	nd / Depa 11-28-	artmer	nt of H as	lealth a Death	nd Me	ental Hy 0 12-2	gien	005	37760
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	Exami	ier 6	711 Birch Avenue					saden		Death		4	c. County of De Anne Ar	
2	Funeral		Social Security Number     6.	Sex 7. Ag		last birthday)	If Unde	r 1 Year Days	If Under 2	4 Hrs.	B. Date of Bir (Month, Da	rth av. Yea	9. B	irthplace (State or Foreign Country)
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003	ural', c	d by	3 ☐ Widowed 4 💢 Divorced	If Yes, Give Year or Dates:			1 🗌 Yes	2LX No	Specify:				Specify:	White
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Maryland 21215-0036	should nd Men i marke umatic	To	Ronald		Amon					emary				scio
Ma	C1 00 = 10		19a. Informant's Name/Relationship Richard C. Amon	(Brother)		196. Mailin	g Addres: COU	s <i>(Str</i> eet a ntrv	nd Number Dav C	or Rural I Cincl	Route Numb e Ft.	ө <i>r, City</i> Мv	or Town, State,	<i>Zip Code)</i> а. 33913
re,	es 1 and 2 of Health fitem 27 r other tr		20a. Method of Disposition		20b. F	Place of Dispo	sition (Na.	me of		Da			ocation - City o	
Baltimore,	Page ment ant: If ury or		1 ☐ Burial 2 【XCremation 3 [ 4 ☐ Donation 5 ☐ Other (Spec			tro Cre	emato	ry Ir	nc. 11	/23/	05	Ba1	timore.	Maryland
Balt	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Lice			22	. Name ar	nd Addres	s of Facility	Stal	lings	Fun	eral Ho	me PA
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P.O. Box 68	I the death certifi by the attending a ached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 🗆 Fetal	Ideath 3	Ectopic pi Other (sp						23d. Date of de Month	elivery Day Year
S, F	res tha igned I be det	þ	Part II. Other significant conditions	contributing to death be	ut not rest	ulting in the un	derlying o	ause give	n in Part I.		23e. Did to	obacco		to the cause of death?
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sio	Attending r death.	catle	2 Accident investigation 3 Suicide 6 Calculd not the	11-17-03	)	12:30	Рм	1 🗆 Y	es <b>X</b> □No					
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			· Unetz_					OC	ME		7	Nove	mber 18	3. 2005
			30. Name and address of person who	completed cause of de	ath (Item	23а) (Туре, Р		-	~.					
10 m	Sta	te	31. Date filed (Month, Day, Year)	32. Pagistra	r's Signat	ture			n Stre	eet_	<u>Balti</u> r	nore	, Maryl	and 21201
\	Registr		NOV 2 3 2	005		H L	ast i							

			1 - For Stata Registrar	State of Ma	aryland /		irtment of H tificate of i			giene Reg. No. () (	5 377	61
	Physici	an	1. Decedent's Name (First, Middle						2. Date of De Month	ath Day	3. Time of D	)eath
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	Examir	er	4a. Facility Name (If not institution				4b. City, Town, or	Location of Deati	1	4c. County	of Death	
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	Funeral Director		5. Social Security Number 217–20–3875	6. Sex 7. Ag 1 ☐ M 2 ☐ F	e (In yrs. last b	Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Apr 22	y, Year)	Birthplace (State or Country)     NC.	Foreign
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38	filed within 72 hours after death with the Maryland Hygiene. ther then "netural", or items 23a or 28a-f show ith, the Mucinal Examiner must be multified at	by F	3 ☐ Widowed 4 ☐ Divorced	ed 1 ☐ Yes 2 ☑ N ff Yes, Give A Year or Dates:	10	1	☐ Yes 2X No	Specify:		Specify	w White	
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Ja	should be nd Mental marked o	To	Adolphus Le					Maggie	Winbur	n		
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	s 1 and 2 should if Health and Men item 27 is marke other traumatic		Mr. William S.	Alexander		7200	Third Av	enue (C4		sville.	MD 21784	
ltimore,	Peges 1 and neut of Heat Int: If item Iry or othe		20a. Method of Disposition	3 □Removal from State			ition (Name of atory or other place		Date		City or Town, State	
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Ball	permit. Peges Department of Important: If it any injury or once.		21. Signature of Funeral Service I	whee Hav	H	HA Sy	Name and Address IGHT FUN kesville	ERAL HOM	E & CHAI	PEL, PA	(Box 195)	
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caused	the death. Do	not ente	r the mode of dyin	g, such as cardiac	or respiratory ai	rest,	Approximate Interval Between	000
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Division of	F 8 F C	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 28e. Place of fnju building, etc	ry - At home, f :. (Specify)	arm, stre	et, factory, office		28f. Location (S City or Tox	itreet and Numbern, State)	er or Rural Route Numbe	3r,
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	Hosi 24 ho Fun Fun	edicai	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the best of xaminer: On the basis of	examination a	je, death nd/or inv	occurred at the time estigation, in my op	e, date and place, pinion, death occur	and due to the or red at the time, or	cause(s) and mai date and place, a	nner as stated. and due to the cause(s)	
	To the Hospital of within 24 hours af To the Funeral D completely filled in	Mec	29b. Signature and title of certifier	and manner sta	100.		29c. License				(Month, Day, Year)	
	- 3 <del>-</del> 5		Porte ?	· Mon.	MD		13	2882			9/05	
	01					(Type P				-		
	10		30. Name and address of person v	. MOSS	//	5/	Basin	· C	v-/	O. K	einfrenton.	n, MX
	Sta	te	31. Date filed (Month, Day, Year)	32. Paristra	r's Signature							
	Registr	ar	NOV 2 3	2005	as St.	190	wis					

Physician Marjorie Leslie Aaron    Marjorie Leslie Aaron   Marjorie Leslie Aaron   Marjorie Leslie Aaron   Marjorie Leslie Aaron   Marjorie Leslie Aaron   Marjorie Leslie Aaron   Marjorie Leslie Aaron   Marjorie Leslie Aaron   Marjorie Leslie Aaron   Marjorie Leslie Aaron   Marjorie Leslie Aaron   Marjorie Leslie Aaron   Sykesville   Sykesvi	mber 21 2005 8:20pm M  4c. County of Death Carroll  Significant Significant Country)  9. Birthplace (State or Foreign Country)  Md  10d. Inside City Limits  1 □ Yes 2 ▼ No
4a. Facility Name (If not institution, give street and number) Continuum Care At Sykesville  Funeral Director  Social Security Number 216-40-4043  Location of Death Sykesville  5. Social Security Number 216-40-4043  Location of Death Sykesville  7. Age (In yrs. last birthday) Months Days Hours Min. Dec Month Dec Mo	4c. County of Death Carroll  Significant State of Foreign Country) 30 1942  9. Birthplace (State or Foreign Country) Md  10d. Inside City Limits 1 1 Yes 2 No
Funeral Director  5. Social Security Number 216-40-4043  1 M 2 M F 62  Vrs.   1 If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Oec (Month Dec.)  Usual Residence of Decedent	30 1942   Md   10d. Inside City Limits   1 □ Yes 2 № No
	1 ☐ Yes 2 No
Md Howard Ellicott City  10e. Street and Number 3357 B North Chatham Road 21042  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or Armed Forces?)  14	
10e. Street and Number 3357 B North Chatham Road 21042 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes of the Armed Forces?) 14. Was Decedent of Hispanic Origin? (Specify Yes of the Armed Forces?) 15. Was Decedent of Hispanic Origin? (Specify Yes of the Armed Forces?)	10= Citizen of Whet Country?
11. Marital Status  12. Was Decedent Ever in U.S.  13. Was Decedent of Hispanic Origin? (Specify Yes of the Armed Forces?)  14. Marital Status  15. Was Decedent Ever in U.S.  16. Yes specify Cuban Mayisan Busch Biggs at the Company of the Company	10g. Citizen of What Country? USA
U 1 □ Never Married 2 □ Married 1 □ Yes 2√√√√√√√√√√√√√√√√√√√√√√√√√√√√√√√√√√√√	
15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
The state of the s	domestic
To see the see that the second see the second see the second see the second sec	· ·
The state of the s	
Teresa Benway (daughter) 896 Piketown Rd., Harrisbur	
20a. Method of Disposition  1 Durial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee  22. Name and Address of Facility  22. Name and Address of Facility  22. Name and Address of Facility  23. Name and Address of Facility  24. Donation 5 Date	20c. Location - City or Town, State
All County Cremation   11-23-05   All Co	Sykesville Md Funeral Home & Chapel
1.0. Box 195 Sykesville	, Md 21784
23a. Pert1. Enter the disease, or complications (hat caused the death. Do not enter the mode of dying, such as cardiac or respirator shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	Interval Batween Onset and Death
Sequentially list conditions, farry, backing to fin modulate cause. Enter Underlying Cause (Disease or injury	
that initiated events c. Due to (or as a consequence of)	
ificate be expression in the physician is the burial buria	
Work?    Signature   Content   Conte	23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. If the part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	Did tobacco use contribute to the cause of death?
To the state of lining to the state of lining	Was an utopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No
25. Was case referred to medical examiner?  26. Place of Death (Check of Death of Death of Check of Death of Death of Death of Death of Death of Death of Death of Death of Death of Death of Death of Death of De	nly one) Residence 6 □Other (Specify)
O 1   Yes 2	ibe how injury occurred
27. Manner Teath 1	on (Street and Number or Rural Route Number, Town, State)
29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to (Check only (Check only 2) Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time.	the cause(s) and manner as stated. me, date and place, and due to the cause(s)
29a. Certifier    Continue   Continue   Continue   Continue	the cause(s) and manner as stated. me, date and place, and due to the cause(s)  29d. Date signed (Month, Day, Year)
29a. Certifler (Check only one)  29a. Certifler (Check only one)  29b. Signature and the offentier  29b. Signature and the offentier  29c. License number  29c. License number  29c. License number  29c. License number	me, date and place, and due to the cause(s)
29a. Certifler (Check only one)  29b. Signature and the orderifler  29b. Signature and address of person who completed cause of death (Item 23a) (Type, Print)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  37b. Raman B Kanera 349 Malelm death occurred at the time, date and place, and due to examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to examination and/or investigation, in my opinion, death occurred at the time, date and due to examination and/or investigation, in my opinion, death occurred at the time, date and due to examination and/or investigation, in my opinion, death occurred at the time, date and due to examination and/or investigation, in my opinion, death occurred at the time, date a	me, date and place, and due to the cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend items 10b c.e. f. 16a, b. per fh. 8849 11-22-05 vt. State of Maryland Department of Health and Mental Hygiene. 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Year **Physician** ALLEN 20 HELEN 0555 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner ELLICOTT CITY REHABILITATION RIDGE RO HOWARD ELLICOTI CITY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 8 16 1914 **Funeral** 9. Birthplace (State or Foreign 1 M 2 F Months Days Hours Min. 219 16 6938 Director MARYLAND Usual Residence of Decedent the Maryland 10a. State 10b. County Carroll 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Madical Examinism must be motified at Sykesville HOWARD MO 1 ☐ Yes 2 No Director 13362 Grinstead Ct 10e. Street and Number 10f. Zíp Code 10g. Citizen of What Country? 21784 APT USA 21043 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after in nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or Ite 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: AA þ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Teacher 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Education Elementary/Secondary (0-12) 12TH College (1-4or 5+) YEARS GOVERNMENT STATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) VIOLA BENNETT ARTHUR HARMON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ARTHUR ALLEN/SON 13362 GRINSTEAD CT., SYKESVILLE, MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State MD 1 Nurial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) injury or permit. Page Department of Important: If any injury or CRESTLAWN MEM. GARDENS 11/29/05 MARRIOTTSVILLE al Service Licensee 21. Signature of 22. Name and Address of Facility HOWELL FUNERAL HOME 4600 LIBERTY HEIGHTS AVE, BALTIMORE, MD (er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician /Medical Due to (or as a consequence of): heart **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical as the IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ģ in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Nhknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an 2000 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 Z No 2 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: al or Attending P s after death. 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 3064 November 21 2005 and

Registrar

State

Dalhi

32. Registrar's Signature

201-109 Back RIVER NECK Road Bulling Magh

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ba.

20

a mes

31. Date filed (Month, Day, Year)

			A	epartment of Health and M Certificate of Death	ental Hygie		
	Physici /Medio	al	1. Decedent's Name (First, Middle, Last)  Catherine Bowersock  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	2. Date of Death Month Novembu	Day Year 18 2005	3. Time of Death
	Examir Funeral Director	ier	5. Social Security Number 6. Sex 7. Age (In yrs. last birth	Baltmore  If Under 1 Year   If Under 24 Hrs.   Months Days Hours Min.	8. Date of Birth (Month, Day, Ye DEC 23 /	4c. County of Death  9. Birth  Par)  9. AS	nplace (State or Foreign untry) SACHUS ETTS
	se Maryland	Director	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town  MD. ANNE ARUNDEL LINT				10d. Inside City Limits 1 ☐ Yes 2 🕮 10
-0036	be filed within 72 hours after death with the Maryland rial Hygiene. ad othar than "natural", or Items 23a or 28a-f show othar than "natural", or Items 23a or 28a-f show event. Ite Madical Exerciter must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 Property Silve Year or Dates:	10f. Zip Code  21090  13. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto F	cify Yes or No- Rican, etc.)	Citizen of What Con  USA  14. Race - Amer Black, White Specify: Wh	ican Indian, , etc. +/TE
2121	e filed within 72 Il Hygiene. othar than "nat vant, ine Midic	e Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)  7. Father's Name (First, Middle, Last)	Decedent's Usual Occupation Give kind of work done during most of workin life. DO NOT use retired)  ECEPTIONIST  18. Mother's Name	D	EWT/ST	, 
Maryland	ges 1 and 2 should be nt of Health and Mental if itam 27 Is marked o or other traumatic eve	To B	FREDERICK PA  19a. Informant's Name/Relationship (Type, Print)  19b. I	SCHE MAA Mailing Address (Street and Number or Rural	Route Number, Ci	COC ty or Town, State, Zi	p Code)
o,	artmer artmer ortant injury		AILEEN CRAWFORD, DAUGHTER  20a. Method of Disposition  1 Deurial 2 Cremation 3 Removal from State  1 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee	Disposition (Name of crematory or other place)  AVEN MEMCLIAL  22. Name and Address of Facility GON			
	permi Depa Impo		23a. Part1. Enter the disease or complications that caused the death. Do no shock, or heart failure last only one cause on each line.  Immediate Cause (Final disease or condition	4001 RITCHIE HWY	BALTO	MD	Approximate Interval Between Onset and Death
	Medical  The private of the private	dical Examiner	Sequentially list conditions, if any, reading, to immediate	In farction			8 minutes 15 years
.O. Box 68	ne death certifi the attending p thed for use as	Physiclan/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of deliv Month	ery Day Year
ords, P	w requires that the back of the by should be detack	by	Part II. Other significant conditions contributing to death but not resulting in t	he underlying cause given in Part I.	23e. Did tobacc	co use contribute to t	
		e Completed	25. Was case referred to medical	26. Place of Death	24a. Was an autopsy performed 1 Yes 2 (Check anly one)	prior to co	opsy findings available impletion of cause of
Division of V	Jing Phys	Certification; To B	examiner?  1 Yes 22 No  27. Manner of Death  1 Natural 5 Pending investigation  3 Suicide 6 Could not be determined to the determined suice.	atient 3 DOA Other: 4 Nursing Home of 28c. Injury at Work?  M 1 Yes 2 No	e 5 Residence	6 Other (Special Special	
D.	To the Hospital or Attand within 24 hours after death To the Funeral Director: completely filled in by the	edical Certif	29a. Certifier (Check only  Medical Examiner: On the basis of examination and/	feath occurred at the time, date and place, and privestication, in my opinion, death occurred	City or Town, St	e(s) and manner as s	tated.
	To the within To the Comple	Med	29b. Signature and title of certifier  WMM JAMMUCL MO	29c. License number 0005 20 22	29d. [	Date signed (Month,	Day, Year) 18, 2005
	Sta Registr		30. Name and address of person o come etcl ause of death (Item 23a) (Ty Andrews of Death (Item	29c. License number  00052022  (pe, Print)  a bor Hospital Ga	Himore,	Maryland	2/225

			For State Registrar		State o	of Maryla		•	ırtment <i>tificate</i>				lental Hyg	giene	005	377	65
N. F	हैं , श्रेटम		1. Decedent's Name (First, Mid-	die, Last)									2. Date of Dea Month	ith Day	Year	3. Time of	
	Physici /Medic		Beatrio	:e		C.			Buckn	er			Novem	,	21 200	5 0648	S AP M
	Examin		4a. Facility Name (If not instituti							_	Location			4c.	County of Dea	ath	
	4-07	ě	Union Memor	al H	ospita	al 7. Age (In y	ere lant his	th day.	If Under		imor If Under		9 Date of Birth		NA	rthplace (State o	r Foreign
	Funeral Director		5. Social Security Number		M 2 <b>⊠</b> F			Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day	, <sub>Year)</sub> 29-27	0	ountry) Md.	rureigir
94.			215-22-4566 Usual Residence of Decedent										10 0	., .,			
	how		10a. State 10b. Coun	ty		10c.	City, Tow	n or Lo	cation							10d. Inside Ci	•
	Be-f e	cto	Md.	N	JA			Bal	timor							1 X Yes	2 [ NO
	vith th	Dire	10e. Street and Number						10f. Zip					10g. Citiz	zen of What C	ountry?	
	e 23s	Funeral Director	307 Whitri			edent Ever i	n II S	13 \	Was Deced	212		igin? (Sp	acify Yes or No-	. 1	USA 14. Race - Am	erican Indian.	
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and	ould be t Mental b larked of	) Be	Ralph	, 2001)			Mead	e				ouise				ith	
Maryland	S D E E	၉	19a. Informant's Name/Relation	nship <i>(Typ</i>	e, Print)				g Address	(Street a			al Route Numbe	r, City or			
	nd 2 alth ar		Calvin Buckne	r	S	Son		307	Whi	trid	ge A	venue	e, Balti	.more	e, Md.	21218	
Je,	of Health of Health fitem 27 r other t		20a. Method of Disposition			1	b. Place of	f Dispo	sition (Nam	ne of ther place	a)	-	Date	20c. Lo	cation - City o	r Town, State	
E	Page nent o		1 □ Burial 2 □ Cremation 4 □ Donation 5 □ Other	1 3 ⊔He (Specify)	movai from	State	Garr	iso	n For	est	Vet	11-3	30-05	Owi	ngs Mi	lls, Md	
Baltimore,	permit. Pages 1 Department of H Importent: If its any njury or ot once.		21. Signature of Funeral Service	License	<u></u>				. Name an March				Baltim 1101 E		Md. orth Av		
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	/Medical Examiner		resulting in death)	(	Due to	(or as a con	sequence	of):			-						
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	led nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury														
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8760,	death certificate be executed e attending physicien and ind for use as the burial-transit																
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Box 6	death certifica attending ph d for use as th	an/N	IF FEMALE: 23b. Was decedent pregnant	23		utcome of pre		3 [	Ectopic pr	egnancy				2	3d. Date of de	•	rear
O. III	the att	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown			nant at time			Other (sp						MOHIII	Day	i bai
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<u>&gt;</u>	9 v =	To B	examiner? 1 ☐ Yes 2 ☑ No	Ho	spital:	Inpatient	2 □ ER/Oι	utpatier	t 3 DC	Othe			me 5 Resid		3 □Other (Sp	ecify)	
	iding Phys th. : Alter this funeral di		27. Manner of Death 1 Matural 5 ☐ Pen	ding	28a. Date (Mo)	of Injury nth, Day Yea	28b.	Time of	2	8c. Injury Work	at		28d. Describe h	ow injun	y occurred		
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Division	or Att	Certification:		mined		e of Injury - Adding, etc. (Sp.		arm, str	eet, factory	, office			28f. Location (S City or Tox			Rural Route Num	ber,
	Hospitel	ဒီ	29a. Certifier 1 <b>Certif</b>	ing Phys	icien: To th	a bast of my	knowledge	e deat	2 Occurred	at the tim	no dato a	nd place	and due to the		and manner	s stated	
	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edicai			er: On the l											e to the cause(s	;)
	To the Within To the	₩ ¥	29b. Signature and title of certi								e number					nth, Day, Year)	_
	d		▶ Kouatehi	ou,	WD				A	IT ZL	1380	746	1	400	ember	21 200	5
1	0		30. Name and address of person Jocelyne K	on who cor	npleted cau	use of death	(Item 23a)	(Type,	Print)	em	oric	all	tospit	al	, M	D	
	Sta Regist		31. Date filed (Month, Day, Ye.		05	Registrar's S	ignature	A	arti	,							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. U 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Timothy 4:17a 11 Barr 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Joseph Richy Hospice Baltimore NA If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 √ M 2 □ F Months 8-20-54 Director 219-62-3680 51 Md. Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits 10b County 28a-f ehow the Medical Examiner must be notified at 1√ Yes 2 No Director Md. NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ or Items 23s 2027 Crestview Road Be Completed by Funeral 21239 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 3 ☐Widowed 4 ☐ Divorced 'naturel', 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "na eny injury or other traumatic event, The Madie page. College (1-4or 5+) Elementary/Secondary (0-12) Chef 12th grade Varies 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Charlie Barr Anna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thelma Diane O'Loughlin Sister 2027 Crestview Road, Baltimore, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Creenmount Cem. 11-23-05 Baltimore, Md. 21. Signature of Suneral Service Licensee 22. Name and Address of Facility Baltimore, Md. 21202 lun March F.H. East 1101 E. North Avenue 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? ō Month 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown É Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death Medical Certification: To Be Completed by should be 3 Probably 4 Phnknown 1 Yes 2 No 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy 1 Yes 2 No 20 funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 2 100 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes』 6 Dother (Specify) 27. Manper of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident the f within 24 hours after deal To the Funerel Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

To the Hospitel State Registrar DHMH 17 Rev 1/2001

29b. Signature and title of certified

31. Date filed (Month, Day,

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29c. License number

and manner stated.

			For State Registrar	State of Marylan		artment rtificate				Reg. No.	05	37767
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) Alexander J. Br	us					2. Date of D Month NOV •	16°,	2005	3. Time of Death
	Examin Funeral	ţ.	4a. Facility Name (If not institution, give Sinai Hospita  5. Social Security Number 6. Se	1	last birthday)	Ba If Under	alti 1 Year	Location of Death LMOT C If Under 24 Hrs.	8. Date of B	irth	nty of Death  A  9. Birthp	lace (State or Foreign
	Director		Usual Residence of Decedent	₹M 2□F 7	2 Yrs.	Months	Days	Hours Min.	2/11	/33		yland
	death with the Maryland ims 23s or 28a-f show	ector	Md 10a. Street and Number		y, Town or Lo Balti		Code			10g Citizen	of What Cour	0d. Inside City Limits  1   Yes 2   No  ntry?
213-0036	72 hours after "naturel", or Ite	Completed by Funeral Director	6416 Bushey St.  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  15. Decedent's Edu (Specify only highest grad	12. Was Decedent Ever in U. Armed Forces? 1 € Yes 2 ☐ No If Yes, Give Year or Dates:	16a. Dece	Was Decedif Yes, spec	21 ent of His fy Cubar No	luring most of work		U   14.     Spe	SA Race - Americ Black, White, ecify: US	an Indian, etc. A dustry
yland 214	ba d o	To Be Com	17. Father's Name (First, Middle, Last)  James Brush	0	Т	ruck	Dri	iver 18. Mother's Nam Stell		1		ucking
Mar	s 1 and 2 should of Health and Men Item 27 le marke other traumatic		19a. Informant's Name/Relationship (7)  Mrs. Michelle  20a. Method of Disposition	Barnett 20b. F	7247	Bric	lgew	nnd Number or Rui		imore		21224
Baltimore,	Pages ment of ant: If It ury or o		1 ★Burial 2 Cremation 3 F  '4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licens	Removal from State Sac Man	cretery cre ry Ce	Heart meter	ber plat Y	9)	19/05	Dune	dalk,	
n n	Departi Depart Import any inj		23a. Part1. Enter the disease of compleshock, or heart failure. List only o	Castro /	1	201 I	Dund	lalk Ave	e. Bal	timor	e, Md	Approximate Interval Between
1,097	death certificate be exacuted  Medical  e attending physician and purial-transit  for use as the burial-transit	icai Examiner	Immediate Cause (Final disease or condition resulting in death)	a. A CROWS Due to (or as a conseq b. — Due to (or as a conseq c. — Due to (or as a conseq d. —	uence of):	otic	Co	erdion	)asu	ler D	isose	Onset and Death
O. Box 68	death certific e attending p d for usa as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d	I death 3	□Ectopic pre				23d.	Date of delive	ary Day Year
ecords, P.	The law requires that the site has been signed by the bage 2 should be detache	by	Part II. Other significant conditions co	ntributing to death but not res	ulting in the u	underlying ca	ause give	en in Part I.		tobacco use o		ne cause of death?
Y		Completed								opsy formed?	b. Were auto prior to co death? 1  Yes	psy findings available impletion of cause of No
Division of Vital	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	atlon: To Be	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigation	Hospital: 1 ☐ Inpatient 2 2  28a. Date of Injury (Month, Day Year)	ER/Outpatie 28b. Time o Injury		8c. Injury Work	4 🗀 Nursing n	ome 5 Res			у)
Divisi	el or Attendi s after death. al Director: A ad in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Specil		reet, factory	r, office			(Street and No own, State)	umber or Rura	al Route Number,
	To the Hospitel or Attenwithin 24 hours after deatl To the Funerel Director: completely filled in by the	edical	(Check only 2 Medical Exam	vsician: To the best of my kno iner: On the basis of examina and manner stated.	tion and/or in	vostigation	in my or	ninion death occur	read at the time	date and nla	ca and due to	the cause(s)
}	To To con	M	29b. Signature and title of certifier  Lagett A	R	M.D	D 290	47	e number 7405 t. Bal		//// Date sig	7/05	∪ay, redi)
/	- Ct	ata -	30, Name and address of person who of the person who do not be seen and address of person who do not be seen and address of person who do not be seen and address of person who do not be seen and address of person who do	ompleted cause of death (Iter	n 23a) (Type	rint)	J S	t. Bal	timor	a Mi	D 21:	201
	Sta Regist			105 Almera.	H. A.	parke	•					

				artment of Health and M rtificate of Death	, ,	ene 1.02005 37768
	Physici /Medic		Deverty Ducter	İ	2. Date of Death Month OVEMbe	Day Year 3. Time of Death 2 2005 4:30A M
	Examir		4a. Facility Name (If not institution, give street and number) 616 Admiral Dr. Apt 354	4b. City, Town, or Location of Death Annapolis		4c. County of Death Anne Arundel
	Funeral Director		5. Social Security Number  6. Sex  1 M 2 F 7. Age (In yrs. last birthday)  217-56-3320  Usual Residence of Decedent		8. Date of Birth (Month, Day, Y OCt 4	
	Maryland a-f show	tor	10a. State 10b. County 10c. City, Town or Lo			10d. Inside City Limits 1∭X Yes 2 ☐ No
	with the	I Dire	10e. Street and Number 616 Admiral Dr. Apt 354	10f. Zip Code 21401	100	g. Citizen of What Country? USA
5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Deportment of Health and Mental Hygiene. Deportment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any njurty or other traumatic event, the Medical Examiner must be multiled at once.	by Funeral Director	11. Marital Status  1 Never Married  Married  Number	Was Decedent of Hispanic Origin? (Sperif Yes, specify Cuban, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: Black
21215-0	d within 72 ho jiene. ir than "natur irie Medical i	Completed	College (1-40r 5+)	dent's Usual Occupation kind of work done during most of workin DO NOT use retired) Ses Assistant		Sb. Kind of Business/Industry Anne Arundel Medical Center
and	ould be fite Mental Hyg tarked othe	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name Ethel B	(First, Middle, Ma	
Maryland	2 should and Me la mark raumation	2	19a. Informant's Name/Relationship (Type, Print) 19b. Mailir	ng Address (Street and Number or Rural	l Route Number, C	
Baltimore, N	Pages 1 and ent of Health nt: If item 27 ry or other to		20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State  20b. Place of Disposition  1 Protop as	esition (Name of Desire of Participal August 11_1	ate 20	nnapolis, Md.21401 c. Location - City or Town, State Annapolis, Md.
Baltin	permit. F Departm Importat any njut		21. Signature of Funeral Service Licensee Muc-1/8 2 2	ens Name and Address of Facility M. Reese & Sons 21 West St. Ann	Mortua	ry, P.A.
~	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not ent shock, or heart falure. List only one cause on each line.	er the mode of dying, such as cardiac or	respiratory arrest	Approximate Interval Between Onset and Death
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	sate be executed physician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Ciscae or Injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):			
8760,	cate be e physician the buria		d			
.O. Box 6	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medical		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
ords, P	w requires that been signed b should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the u	nderfying cause given in Part I.	23e. Did tobac	cco use contribute to the cause of death?
al Records,	The ate h page	Completed			24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death?  1  Yes 2 No
f Vital	Physicien: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner?  1 \( \times \) Yes 2 \( \times \) No Hospital: 1 \( \times \) Inpatient 2 \( \times \) ER/Outpatien	26. Place of Death at 3 DOA Other: 4 Nursing Hom		e 6 ⊡Other (Specify)
Division of	tending eath. or: After the fune	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	8d. Describe how	injury occurred
Divi	tal or Attendestiss after death	Certifi	4 Homicide determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	et, factory, office 28	8f. Location (Stree City or Town, S	at and Number or Rural Route Number, State)
	To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by	Medical	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death and one one of the death of the	vestigation, in my opinion, death occurred	d at the time, date	and place, and due to the cause(s)
	S S S S S S S S S S S S S S S S S S S		29b. Signature and fittle of pertifier    Signature and fittle of pertifier   Signature	29c. License number 01983		Date signed (Month, Day, Year)  [1] 14/2005  [Annopolis Wo
12			30. Name and address of person who completed cause of death (Item 23a) (Type, STUAVE, SCOULC, WO	900 Bestac	ate Ro	1. Annopolis Wo
	Sta Registr		31. Date filed (Month, Day, Year)  32. Registrar's Signature			

05-07719 AMAYA C BELL WHM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend item# 23a,27,28a-f.pen/E,0851,1/5/06 TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav **Physician** NOVEMBER 15, 2005 6:18 P M HMAUA /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JOHNS HOPKINS HOSPITAL BALTIMORE CITY If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 D Months Yrs. Director 219-69-6283 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County or 28a-f show or other traumatic avent, the Medical Examiner must be notified at 1 Pres 2 □ No Director Balhmore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 403 USA 23a NVENUE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Iteme Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 "natural", or Specify: BLACK þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If teem 27 ie marked other than "ne any injury or other traumatic avent, tra Modic 2005. Elementary/Secondary (0-12) College (1-4or 5+) IN Fant Never Worked 0 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First, Middle, Last) Be 0 Webster DOMINIC arlene 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 903 Date Da / Himore MB 2/22

20c. Location - City or Town, State arlene A. Webster-MD 21224 Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Sacred Heart of Jesus Cem. 11/21/05 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Bradley-Askton Funeral Home, P.A HOLL 2134 WILLOW Spring Rd. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Asphxia Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine ed by the attending physicien and detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Day Month Yea 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by sete has been sign page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificete has autopsy performed? 1 Yes 2 🗆 No Hospital or Attanding Physician: 25. Was case referred to medical examiner?
1 XYes 2 □ No Be 26. Place of Death (Check only one) Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 27. Manner of Death Pha. Date of Injury Month, Day Year) Find jury 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural To the Hospital or Attanding within 24 hours after death.

To the Funeral Director: After completely filled in by the fun 1 ☐ Yes 2 📉 No 11/14/05 10:00 A 2 Accident 6 Could not be 3 🗌 Suicide 28f. Location (Street and-Number or Rural Route Number, City or Town, State) 903 Dalton Avenue 28e. Place of Injury - At home, farm; street, factory, office building, etc. (Specify) 4 Homicide Found at residence Baltimore, MAryland 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

31. Date filed (Month, Day, Year) State NOV 2 3 2005 Registrar

(Check only one)

29b. Signature and title of certifier

LING

hi

LI

miD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Resistrar's Signature

111 PENN STREET, BALTIMORE, MARYLAND, 21201

29c. License number

OCME

29d. Date signed (Month. Day, Year)

NOVEMBER 16, 2005

		roi .	artment of Health and Ment		ene LN2005 37770
G		Decedent's Name (First, Middle, Last)		ate of Death	3. Time of Death
Physic /Medi		Joseph Howard Burriss, Sr.		vember	Day Year 18, 2005 11:23a M
Exami		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
		Carroll County Hospital	Westminster		Carroll
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Months Days Hours Min. (A	ate of Birth Nonth, Day, Y	(ear) 9. Birthplace (State or Foreign Country)
Director		216-30-8604 70 70	Mar	rch 12	, 1935 Maryland
and w		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Lo	cation		10d. Inside City Limits
Mary f sho	ğ	Maryland Carroll Westminste	r		1 ☐ Yes 2 €☐ No
28a	rec	10e. Street and Number	10f. Zip Code	100	. Citizen of What Country?
3a of	Ö	20 Liberty St., 4-B	21157		U.S.A.
death	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. V	Was Decedent of Hispanic Origin? (Specify Yes, specify Cuban, Mexican, Puerto Rican	Yes or No-	14. Race - American Indian,
after or Its	F	1 Never Married 2 Married 1 Yes 2 No	i Tes, specily Cuban, Mexican, Pueno Hican	i, etc.)	Black, White, etc.  Specify:
hours a	d by	3 Widowed 4 Divorced Year or Dates:			White
72 h	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Deced	dent's Usual Occupation kind of work done during most of working DO NOT use retired)	16	6b. Kind of Business/Industry
within the same.	E D	Elementary/Secondary (0-12) College (1-4or 5+) Forema			Agriculture
Hygie ther		17. Father's Name (First, Middle, Last)	18. Mother's Name (Firs		
d be and all codes	To Be	Orlando Burriss		ıvall	,
at yieliti 4 is 13-0030 should be filed within 72 hours after death with the Maryland nd Mental Hygiene. It marked other than "naturel", or Items 23a or 28a-f show unatice event, the Modical Exemples must be routilised at	1		ng Address (Street and Number or Rural Rou		City or Town, State, Zip Code)
nd 2 s alth an 27 ls a		Betty Buriss- Wife 20 Li	iberty St., 4-B, West	tminste	er, MD 21157
ore, M ss 1 and 2 of Health litem 27 I		20a. Method of Disposition 20b. Place of Dispo	sition (Name of Date natory or other place)	20	c. Location - City or Town, State
Pages nenl of I		1 X Burial 2 U Cremation 3 U Hemoval from State	e Memorial Park 11/23/20	005 E	lkridge, MAryland
Dallimore, Marylaniu Z IZ 13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "nature!", or Items 23a or 28a-f show any njurry or other treumatic event, the Medical Examiner must be notified at 2008.			. Name and Address of Facility	al Home	a at MMD TNC
D 89789		Mogh 72	ary L. Kaufman Funera 250 Washington Blvd.,	Elkr	idge, MD 21075
	ı	23a. Part1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.	er the mode of dying, such as cardiac or resp	piratory arres	t, Approximate Interval Between
Pnysician		Immediate Cause (Final disease or condition CARDIO - PUL	MUNARY AIRREST		Onset and Death 20 MINUTES
/Medical Examiner		Due to (or as a consequence of):			
LAGIIIIICI	<u>.</u>	Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):	PHOCYTIC LEUKEN	WA.	5 4VS
ist of	nin	rany, leading to immediate cause. Enter Underlying Cause (Disease or injury			10000
be executed ician and burial-transit	Examin	that initiated events resulting in death) Last			1041)
icate be executed physician and sthe burial-transit	icai E				
death certificate e attending phys	ed				
Goath certific death certific sattending p	J/N	IF FEMALE: 23b. Was decedent pregnant  1 □ Live birth 2 □ Fetal death 3 □	Ectopic pregnancy		23d. Date of delivery
deatle	sicis	in the past 12 months?  1 Yes 2 No  4 Pregnant at time of death 5	Other (specify)		Month Day Year
at the	Physician/M	9 Unknown	- I - David	na Didasha	and the second fibrate to the across of death?
cords, F.O.  wrequires that the de been signed by the.	by	Part II. Other significant conditions contributing to death but not resulting in the un	idenying cause given in Part I.		cco use contribute to the cause of death?  2 \[ \sum No \] 3 \[ \sum Probably \] 4 \[ \sum Unknown \]
w requires been sign	eted				
e law has b	Completed			4a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death?
Vital ne ician: The lav certificate has rector, page 2				☐ Yes 2)	No 1 □Yes 2 □ No
	o Be	25. Was case referred to medical examiner?  1 □ Yes 2 No Hospital: 1 □ Inpatient 2 ► FVOutpatien	26. Place of Death (Che t 3 DOA Other: 4 Nursing Home		0 COhor (0-1-1)
OT Phys or this aral di	Π⊢.	27. Manner of Death 28a. Date of Injury 28b. Time of			injury occurred
on ading	ation	1 Natural 5 Pending (Month, Day Year) Injury 2 Accident Investigation	Work? M 1 ☐ Yes 2 ☐ No		
INISION  or Attending after death. Director: After in by the function	ifica	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office 28f. Lo	ocation (Stre	et and Number or Rural Route Number,
s afte	Certification:	Dulluling, etc. (Specify)		nly or rown,	State)
To the Host itel or Attending Phywithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral	edica (	29a. Certifier 10 Certifying Physician: To the best of my knowledge, death 2 Medical Examiner: On the basis of examination and/or in	occurred at the time, date and place, and diversingation, in my opinion, death occurred at	ue to the cau	se(s) and manner as stated.
the hin 24 the F	Medi	one) and manner stated.	20g Lingers sumbar	00	Data cinned (Month Day Vers)
To To		29b. Signature and title of certifier	D006224=	7	A loss of the signed (world, pay, rear)
4		· Cuma vy- less ms	0000027	4	1000 cm nev 18, 2005
10		30. Name and address of person who completed cause of death (Ital 13a) (Type,	50 MAMAIRIAN ALL	E 11	) GOTHING POLIN
St	ate	31. Date filed (Month, Day, Year)  32. Registrar's Signature	1		7 Mil
Regist		NOV 2 3 2005 Mesers St. A	To see		NOVember 18, 2005  DESTMINATEL, MI

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Clarence Edward Baseman November 19, 2005 1:55 PMM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Care Center @ Oak Crest Village Parkville Baltimore If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) NOV • 13, 1 9. Birthplace (State or Foreign **Funeral 2** M 2 □ F 1922 Maryland 83 Yrs. Director 217-16-5765 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 7 is marked other than "naturel", or Items 23a or 28a-f show treumatic event, the Medical Examinar must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 No Maryland Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8810 Walther Blvd. 21234-5662 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married TXXYes 2 ☐ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 Specify: 1 ☐ Yes 2 No þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry fited within Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Educator State Board of Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental George Bedford Baseman Anne Merryman Ruby 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) C. Majorie Baseman / Wife 8810 Walther Blvd., Baltimore, MD 21234-5662 item 27 l 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages Department of I Importent: If its any injury or o once. 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Hilltop Service Corp. 11-22-05 Towson, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death **Physician** disease or condition resulting in death) stage End /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): death certificate be axecuted that initiated events resulting in death) Last Due to (or as a consequence of) inding physician a use as the burial-68760 Physician/Medical use as Box IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery atter for u 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No o detached 9 Unknown 9 Unknown been signed by should be detacl Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? cate has autopsy performed? certificate 2 No 2 No Vital 1 ☐ Yes director 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Universing Home 5 Residence 6 Other (Specify) 2 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) After thi 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending Division 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: / 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 0 29d. Date signed (Month, Day, Year) - mo D58646 November 21, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 8800 walther Packville, MOZIZZY Borleward Monies mana 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2005 NOV 2

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No... 1 Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** BEWIG KATHERINE ELIZABETH 2005 /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Roseda le If Under 1 Year | If Under 24 Hrs. Franklin Square Hospital altimore 8. Date of Birth (Month, Day, Year) 11-27-1929 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 217-26-2689 1 M 2 XF 75 MARYLAND Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits item 27 is marked other then "natural", or Items 23s or 28s-1 show other traumatic event, the Medical Examiner must be notified at BALTIMORE ROSEDALE MD 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8219 EDWILL AVENUE 21237 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 P No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: WHITE 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) SECRETARY CHURCH 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental **GEORGE** MUTH ALICE (MC GEE) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a important: If item 27 is eny injury or other trai ALAN BEWIG / SON 1292 BRECKENRIDGE CIRCLE RIVA, MD 21140 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1XX urial 2 ☐ Cremation 3 ☐ Removal from State GARDENS OF FAITH CEM. 11-26-2005 Baltimore, 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CVACH ROSEDALE FUNERAL HOME 1211 CHESACO AVENUE ROSEDALE, MD Approximate Interval Between Onset and Death 23a, Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician loidosi disease or condition resulting in death) /Medical Due to (or as/a consequence of): Examiner Disease and Myeloma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of: Examiner the attending physician and the for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) sate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of certificate has Yes 2 No Yes To the Hospital or Attending Physician: funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 1 ☐ Yes 2 ØNo 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending after death. investigation 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) filled in by 4 🗌 Homicide within 24 hours a
To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated -222521-29c. License number 29d. Date signed (Month, Day, Year) (PG9-1) Wom, MID Res0000 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 Franklin Square Drive, Baltimore, MD 21237 Jerry Jaboin, 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar NOV 2 3 2005

State of Maryland / Department of Health and Mental Hygiene | Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav Month Year Physician 12:59a 2005 Black. November /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore
Under 1 Year | If Under 24 Hrs. onths | Days | Hours | Min. N/A 1931 Letitia Avenue 8. Date of Birth (Month, Day, ) June 11, 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthdey) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Year 1923 Months Pennsylvania 82 215-12-4566 Yrs. Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location or items 23a or 28a-f ehow Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mental Hygiene.
she to Health and Med Hygiene.
she if if the X2 is exerted other than "naturel", or litems 23s or 28s-f ehou ury or other traumatic event, its Medical Exertisms from the notities as 1, Yes 2 No Director Baltimore N/A Maryland 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number 21230 USA 1931 Letitia Avenue Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ White 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HVAC Self Employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Black Esther Grimm Bronson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1931 Letitia Avenue, Baltimore, MD 21230 Charolotte A. Black (Wife) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ⊠Burial 2 ☐ Cremation 3 ☐ Removal from State rtment rtant: if njury o \* 4 ☐ Donation 5 ☐ Other (Specify) 11/23/05 Baltimore, Maryland Loudon Park Cemetery 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Licensee Department of the sany in 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part Effective disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician PAYS ONGESTIVE /Medical Due to for as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Physician: The law requires that the death cartificate be executed burial-transit ENERALIZE Due to (or as a consequence of) physician the burial P.O. Box 68760, Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) Yes 9 Unknown 9 Unknown 23e. Did tobaseo use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ 1enu 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Pleura autopsy performed 2 No 1 Yes 2 No 1 Tyes 25. Was case referred to medical examiner? 26. Place of Death (Check only phe) Hospital: Other: 4 Nursing Home 5 esidence 6 Other (Specify) ဥ 1 Tyes 2**-**110 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of Certification: After To the Hospital or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No death. М 2 Accident Diractor: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 / Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated 29c. License number 29b. Signature and title of certifier ATTENDING Physician 16200 n 30. Name and add ss of person who completed cause of death (Item 23a) (Type, Print) 720-CMAIDEN Choice ha N.M. MACHIRAN 32. Registrar's Signature 31. Date filed (Month, Day, Year) Registrar

			1 - For State Registrar		artment of Health and M	lental Hygiene Reg. Nó	0.00
			Decedent's Name (First, Middle, Last)			2. Date of Death Month Day	3. Time of Death
	Physicia /Medic		Katherine Maddock			November 2	
	Examin		4a. Facility Name (If not institution, give street an		4b. City, Town, or Location of Death		. County of Death
			Angels Touch Assisted 5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	West Friendship    If Under 1 Year   If Under 24 Hrs.	9 Date of Birth	OWard  9. Birthplace (State or Foreign
	Funeral Director		037-03-7755		Months Days Hours Min.	(Month, Day, Year) Feb 2 1913	Country)
			Usual Residence of Decedent	40. Oit. T		1713	
	anylar show	7	Md Howard	10c. City, Town or L Sykesv			10d. Inside City Limits 1 ☐ Yes 2√☐ No
	the M	ecto	10e. Street and Number		10f. Zip Code	10a. Cit	tizen of What Country?
	3a or		13375 Pipes Lane		21784		SA
	death	Funeral Director	11 Marital Status 12. Was	Decedent Ever in U.S. 13. ed Forces?	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	<del></del>	14. Race - American Indian, Black, White, etc.
2	or Ite	y Fu	1 Never Married 2 Married 1 If Ye	Yes 2 ThNo s, Give A	1 ☐ Yes 2 ☐ No Specify:		Specify:
- - - -	hours tural',	ed by	3 Widowed 4 □ Divorced Year  15. Decedent's Education	or Dates:	adent's Usual Occupation	16b. K	white Gind of Business/Industry
ה ע	n na n vezis	Completed	(Specify only highest grade comple	oted) (Give life.	a kind of work done during most of work DO NOT use retired)	ing	,
7	d with giene er the	mo.	12	hom	emaker		mestic
yiana	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last) Ritchie Maddock			e (First, Middle, Maiden	ı Sumame)
2	d Men marke	2	19a. Informant's Name/Relationship (Type, Prin.	10b Mail	Harriett		or Town State Zin Code)
20	id 2 st ith and 27 is r traur		Donald M. Benson (son)		5 Pipes Ln., Sykes		
ē,	s 1 and the all the al		20a. Method of Disposition	20b. Place of Disp			ocation - City or Town, State
Ē	Pege nent o ant: If ury or		1  Burial 2  Cremation 3  Removal 4  Donation 5  Other (Specify)	Christ E	piscopal Cem. 11-2	3-05 Fore	est Hill, Md
Бантшо	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heatin and Mertal Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumetic event, the Madical Examplant returned to notified at once.		21. Signature of Funeral Service Licensee Page Haight Service	pert 2	2. Name and Address of Facility Hai P.O. Box 195 Sykes	ght Funeral	l Home & Chapel
			23a. Part1. Enter the disease, or complications shock, or heart failure. List only one cause	that caused the death. Do not er	nter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Musicandia	C Infarction		Onset and Death
	/Medical Examiner		resulting in death)	e to (or as a consequence of):			
	_ Adminion	-	Sequentially list conditions, b	ie to (or as a consequence of).			
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.				
Ď,	sate be executed thy sicien and the burial-transit	Exa		ue to (or as a consequence of):			
8/60	certificate be executed Iding physicien and Ise as the burial-transit	dical	d				
X	leath certifica attending ph I for use as th	Physician/Med	IF FEMALE: 23c. If ye	s, outcome of pregnancy			23d. Date of delivery
X R R	atter for u	Iclar	in the past 1% months?	Pregnant at time of death 5	☐Ectopic pregnancy ☐ Other (specify)		Month Day Year
j.	by the	hys	9 ☐ Unknown 9☐	Unknown		-	
- S	law requires that the de as been signed by the 2 should be detached	۵	Part II. Other significant conditions contributing	to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
ecord	m va n	Completed				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
Vital H	± age σ	e Co	25. Was case referred to medical		OC Plane of Door	1□ Yes No	
	Physician: this certific ral director,	O B	examiner?  1 Yes 2 No Hospital:	1 ☐ Inpatient 2 ☐ ER/Outpatie	Othon	h (Check only one) me 5 Residence	6 ther (Specify)
on O	e fe	tlon: T	27. Manger of Death 28a. Natural 5 Pending	Date of Injury (Month, Day Year) 28b. Time Injury		28d. Describe how inju	<del></del>
Division	To the Hospital or Attending within 24 hours efter death.  To the Funerel Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not be determined 28e.	Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Street ar City or Town, State	nd Number or Rural Route Number, e)
	Hospital 24 hours e Funerel I etely filled	edlcal (	(Check only 2 Medical Examiner: On		th occurred at the time, date and place, nvestigation, in my opinion, death occur		
	To the within 2 To the complet	Me	29b. Signature and title of certifier		29c. License number	29d. Da	ate signed (Month, Day, Year)
)	•		15		1)36780	11-	11-01
	$\mathcal{A}$		30. Name and address of person, who completed	cause of death (Item 23a) (Type	sler ste vien 1	Surnie, n	2.060
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) NOV 2 3 2005	32. Segistrar's Signature	Sporter .		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene state State Registramend Item #11 Per FH G849 119estificatenpf Death Reg No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 9:50 AM 13100m November 2005 20 Harold /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Randallstown Under 1 Year | If Under 24 Hrs. | 8 Hospital Northwest Center BALTIMORE 5. Social Security Number 6 Sax 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 MD Fugêral Days 1 M 2 □ F 83 MD 217-18-3172 Vrs Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County item 27 is marked other than "natural", or itams 23s or 28e-1 show other traumatic event, the Modest Examinar must be notified at 1 ☐ Yes 2 No Director BALTIMORE BALTIMORE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21208 U.S.A. 16 OLD COURT ROAD APT, 303 death Completed by Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or incorporation of the streamatic avenue. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Never Married 2 ☐ Married U.S.A. 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HOME IMPROVEMENT SALES 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be CHOR **BLOOM** LENA MORRIS ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 50 WADDINGTON LANE - ROCKVILLE, MD 20850 IRVING ROSEN / NEPHEW 20b. Place of Disposition (Name of cemetery crematory or other place)
ANSHE EMUNAH
AITZ CHAIM CONG. 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Remov. I from tate 4 ☐ Do at n 5 ☐ Other (Specify) 11/22/2005 BALTIMORE, MD uneral ervice l SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the diseas shock, or heart failure. that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, so on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Multiple Organ System
Due to (orlas a consequence of): tailure disease or condition resulting in death) /Medical Examiner esternic inflammatory response syndrome Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-transit Clostridium di Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) ate has been signed by the a page 2 should be detached to 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ polyneuropathy 1 Yes 2 No 3 Probably 4 Unknown Coronary artery disease Be Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No Anemia ot inflummation ormed? 2 1 No Metabolic Hypertension this certificate 1 Yes bone disease To the Hospitei or Attending Physician: After this certification funeral director, I 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural Injury 5 Pending within 24 hours after death.
To the Funerei Director: Af 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D28462 November 20, 2005 mila 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1 Center Randallstown, Maryland 21133 Northwest Hospital

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

			For Stata Registrar	State of Maryland	•	nt of Health and N te of Death	Mental Hygier	711115	37776
i d	Physicia /Medic		1. Decedent's Name (First, Middle, Las	Carter			2. Date of Death	) Year	3. Time of Death 7.35 9 <sup>M</sup>
	Examin		4a Facility Name (If not instrution, give	s Hospice	T:	Town, or Location of Death			more
- 18	Funeral Director		5. Social Security Number 6. S  241-52-6087  1  Usual Residence of Decedent	9X □ M 25 X F 70	Yrs. II Und	er 1 Year If Under 24 Hrs. S Days Hours Min.	8. Date of Birth (Month, Day, Yea 2-13-	34 9. Birth	place (State or Foreign ntry)
	the Maryland 28a-f ehow	or	10a. State 10b. County	10c. <u>City</u>	Town or Location	nore			10d. Inside City Limits 1 Yes 2 □ No
•	er death with the Maryla Iteme 23a or 28a-f ehov ner must be coulfied at	Direct	10e. Street and Number	a Pl And		21207	10g. (	Citizen of What Cou	ntry?
D D.II	72 hours after death with the Maryland natural', or iteme 23a or 28a-f ehow Jight Evarul at must be coulified at	Funeral Director	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ever in U.S Armed Forces? 1  Yes 2 No If Yes, Give	6. 13. Was Dec	edent of Hispanic Origin? (Specify Cuban, Mexican, Puerto	pecify Yes or No- p Rican, etc.)	14. Race - Ameri Black, White,	
5-0036	72 hours a	ted by	3 Widowed 4 □ Divorced  15. Decedent's Ed. (Specify only highest gra	year or Dates:	16a Decedent's Us	2 No Specify:	16b.	Specify: Kind of Business/In	lacK
2121	d within giene. rr then "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	A /	vork done during most of work use retired)	H	ealth	Care
- E	ed fa	To Be	17. Father's Name (First, Middle, Last)			Deci	e Fly	the	
SEK 19,	s 1 and 2 should I Health and Mer Item 27 is marke other traumatic	4	19a. Informant's Name/Relationship (	:tchell bught	19b. Mailing Adve	ss (Street and Number or Ru	Owings	Location - City or T	121117
NOVEMBER altimore, N	000		20a. Ve d ol Dispy sition  1 X Burial 2 ☐ Cremation 3 ☐  4 Donation 5 ☐ Other (Specification)	Removal from State	ng Memor	altark 11-	26-05 E	Saltimo	re, MD
Ball	permit. Pag Department Importent: I any injury o		21. Signature of Furgral Service Lice	Ireene	8728	Shadresof F@ree Lberty Rd.,	Randall	ral Ger stown, n	nD 21133
	Physician		23a. Part1. Enter the disease, or com shock, or heart lailure. List only Immediate Cause (Final disease or condition	plications that caused the death one cause on each line.  a. ENDOMETRIAL		ode of dying, sum as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)  Sequentially list conditions,	Due to (or as a consequ					
k	e be executed /sician and e burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c					
8760,	icate be ex physician s the burial		(	d					
D. Box 6	eath certif attending for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 M No 9 ☐ Unknown	23c. If yes, outcome of pregnan 1 Live birth 2 Fetal 4 Pregnant at time of de	death 3 Ectopic			23d. Date of deliv Month	ery Day Year
ls, P.O.	ires that the di signed by the i be detached	Ď	Part II. Other significant conditions of	ontributing to death but not resu	Iting in the underlying	g cause given in Part I.		o use contribute to t	the cause of death?
TER Records,	ne law requir has been si ge 2 should	Completed					24a. Was an autopsy performed	24b. Were auto prior to co death?	opsy findings available ompletion of cause of
CARTER Vital Rec	ian: Th	0	25. Was case relerred to medical		12	26. Place of Dea	1 ☐ Yes 2 X th (Check only one)	No 1 ☐ Yes	2□ No
o ⊬	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	ion: To B	examiner?  1  Yes 2 No  27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	ER/Outpatient 3 28b. Time of Injury	DOA Other: 4 Nursing H  28c. Injury at Work?  1 Yes 2 No	ome 5 Residence 28d. Describe how in		h) HOSPICE
DECI Division	or Attencafter death	Certification:	2 Accident investigatio 3 Suicide 6 Could not be determined	e See Blees of Injury At he	me, farm, street, lact		28l. Location (Street City or Town, St	and Number or Run ate)	al Route Number,
	e Hospital 24 hours - e Funeral etely filled	edicai C	29a. Certifier (Check only one)	ysician: To the best of my knowniner: On the basis of examinat and manner stated.	wledge, death occurre ion and/or investigati	ed at the time, date and place on, in my opinion, death occu	, and due to the cause rred at the time, date a	(s) and manner as s and place, and due t	stated. to the cause(s)
	To the within To the complete	Me	29b. Signature and title of certifier		. 2	29c. License number	29d. l	Date signed (Month,	
	1		1 /1-			D43725		11/21/0	5
			30. Name and address of person who			DD MTMANTING	MD 01000		
	Ct.	ate	DR. TARIQ MAHMO 31. Date filed (Month, Day, Year)	OD 2300 DULANE 32 Registrar's Signal		KD. TIMUNIUM	, MD 21093		
	Regist		NOV 2 3 200	All and an an an an an an an an an an an an an					

DHMH 17 Rev 1/2001

ORIGINAL

			For State	State	of Marylan		artment rtificate			and M	lental Hy	giene Reg. No.?	005	27-	777
	*		Registrar  1. Decedent's Name (First, Midd.	e, Last)							2. Date of De	ath	UUU.	3. Time of	Death
	Physicia /Medic		Ambrose Rober	t Cremen,	Jr.						NOV.	22,	2005	9:15	Ам
	Examin		4a. Facility Name (If not institutio	n, give street and n	umber)		4b. City, T						ounty of Deat	1	
			6827 Ridge Ro		7 4-0 (10	land biotholass	Mar If Under 1		tsvi.		8. Date of Bir		rroll	nplace (State o	e Comian
П	Funeral Director		5. Social Security Number 219–38–0665	6. Sex 1 (XM 2 ☐ F	7. Age (In yrs. I			Days	Hours	Min.	NOV. 2	5, Year 194	10 Mai	yland	or roreign
			Usual Residence of Decedent												
	arylan show	_	10a. State 10b. County			, Town or Lo								10d. Inside C 1 ☐ Yes	•
	he Ma	ecto	MD Carr	011	Ma	rriot	10f. Zip (					10a. Citize	n of What Co		7.
	with 1	١	6827 Ridge Ro	ad			211						d Stat		
	death	nera	11. Marital Status	12. Was De	cedent Ever in U. Forces?	S. 13.	Was Decede	ent of His	panic Orig	gin? (Spe	ecify Yes or No Rican, etc.)	o- 14	Race - Ame Black, White		
9	or Ite	by Funeral Director	1 ☐ Never Married 2 ☑ Mar	ned 1 XYes	s 2□No 196	51-	1 Yes 2		Specify:		,,			ite	
21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene death with the Maryland of them 23a or 28a-f show of other than "natural", or items 23a or 28a-f show event, the Madical Exercitival for notified at	d be	3 Widowed 4 Divorced	Year or	Dates: 196	16a Dece	dent's Usual	Occupat	tion			16b. Kind	of Business/		
15	in 72 n "na Madic	plet		st grade complete	d) (1-4or 5+)	(Give	kind of work DO NOT use	done du retired)	uring mos	t of work	ing			curity	
N	giene giene r the	Completed	12			Super	rvisor		naly			1	nistra	tion	
Maryland	be filed ntal Hygie od other	Be	17. Father's Name (First, Middle		C						e (First, Middle A. Swac		ımame)		
7	s 1 and 2 should be if Health end Menta Item 27 is marked other treumatic ev	ဍ	Ambrose Rober  19a. Informant's Name/Relation		, SI.	19b. Maili	ng Address				al Route Numb		own, State, 2	ip Code)	
	2 9 2 3		Mary Cremen	Wife	<b>.</b>	1	_				ottsvi				
Jre,		(8	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	2 Demoval fro	20b. P	lace of Dispo emetery, cre	osition (Nami matory or oth	e of her place	)		Date		tion - City or		
Ë	Pages ment of I ant: If Its ury or o		4 Donation 5 Other (		Dru	uid Ric	-		-	-	8/05	Pike	sville	, MD	
Baltimore,	permit. Page Depertment of Important: If any injury or		21. Signa uri of Funeral Service	Cam		]	1212 W	r-Qu L Öl	een d Li	Fune bert	ral Hor y Road	Winfi	remato eld, M	ry, P., D 2178	A. 4
			23a. art1 Enter the disease, of shock, or heart failure. Lis	r complications that t only one cause of	neagh line.	h. Do not en	ter the mode	of dying	, such as	cardiac	or respiratory a	arrest,	,	Approximation Interval Bet Quiset and	te tween
	Pnysician		Imn edi .e Cause (Final dis lase or condition res illing in death)	a	Melost	the a	olon	cau	109					21 ye	
1	/Medical Examiner		Tooming in douch	Due	to (or as a conseq	uence of):								0	
	1	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Oue	to (or se s donesq	senne offy							- 0		
A	cuted	Examin	Cause (Disease or injury that initiated events	S											
3760,	ate be executed hysicien and the burial-transif		resulting in death) Last	Due	to (or as a conseq	uence of):									
6876	cate b physic s the b	dlcai		d											
Box 6	death certificate be executed e ettending physicien and nd for use as the burial-transif	Physician/Med	IF FEMALE: 23b. Was decedent pregnant		outcome of pregna		75-1					23	d. Date of del		
	deaff	sicia	in the past 12 months? 1 □ Yes 2 □ No		e birth 2 ☐ Feta egnant at time of d known		☐Ectopic pre☐Other (spe						Month	Day	Year
P.0	The law requires that the de Ite has been signed by the o page 2 should be deteched	Phy	9 Unknown Part II. Other significant condit			ulting in the s	ınderiving ca	use dive	n in Part I		23e. Did	tobacco use	cantribute to	the cause of	death?
ds,	uires ti signe Id be o	d by	Part II. Other signmean condi-	ions contributing to	o dodan od not roo	oung in the c	indonying ou	.ues g.ve			1 🗆	Yes 2 🖺	No 3∐Pr	obably 4 🗌	Unknown
Records,	w requ been shoul	Completed									24a. Wa	s an	24b. Were au	topsy findings	available
Re	The lav	шо										ormed?	prior to death?	completion of a	cause of
Vital		BeC	25. Was case referred to medic examiner?	al					26. Place	e of Deat	h (Check only				
of V	Physicien: this certifical director,	ည	1 ☐ Yes 2 🗷 No			ER/Outpatie			4	ursing Ho			Other (Spe	cify)	
	ding P h. After t funera	ion:	27. Manner of Death 1 ☑ Natural 5 ☐ Pend	ing (M	te of Injury lonth, Day Year)	28b. Time o Injury	of 28	Bc. Injury Work	at ? ′es 2.∐	No	28d. Describe	now injury	occurrea		
Division		ficat	3 ☐ Suicide 6 ☐ Could	minord 288. F18	ace of Injury - At h	ome, farm, si	l				28f. Location		Number or Ri	ıral Route Nur	nber,
Ö	E E E	Certification:	4  Homicide deter	bu	ilding, etc. (Special	(y)					City or 10	own, State)			
	To the Hospital or Attentwithin 24 hours effer deat To the Funeral Director: completely filled in by the	Medical	29a. Certifier 1 Certify (Check only 2 Medical	ing Physician: To If Examiner: On the and m	the best of my kno basis of examina anner stated.	owledge, dea ation and/or in	th occurred anvestigation,	at the tim in my op	e, date ar inion, dea	nd place, ath occur	and due to the red at the time	e cause(s) a , date and p	nd manner as lace, and due	stated. to the cause(	s)
	To the To the Comp	ž	29b. Signature and the of certifi	ier				License				29d. Date	signed (Mont	h, Day, Year)	
			· fallet					208				11/2	L/10		
-	2041		30. Name and address of person	[URNOS,	NO	п 23a) (Туре /ООО	Print) LIBER	274	RD	E	LALAS	BUPC	ND	217	84
-	St. Regist	ate rar	31. Date filed (Month, Day, Yea	3 2005	2. Registrar's Signa	ature	Courte	,							
			MUVA	0 6003	Party Const	JAN P	-								

Registrar DHMH 17 Rev 1/2001

State

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10:35

2005

NOVEMBER

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. TARIQ MAHMOOD

31. Date filed (Month, Day, Year) NOV 2 3 2005

			For State	•	partment of Health and Nertificate of Death	Mental Hygien Rag. N	4000 3/1/9
			Ragistrar  1. Decedent's Name (First, Middle, Last)			2. Date of Death	3. Time of Death
	Physicia		DOFOTAL P	-omER			9 05 4:15 0 M
	/Medic Examin		4a. Facility Name (If not institution, give s	treet and number)	4b. City, Town, or Location of Death	4	c. County of Death
1	LAdimit	51	FUTURELARE HOY	newood	BAILIMOSE		NA
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birtho	ay) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birthplace (State or Foreign Country)
	Director		212-34-3590 10	M 2 F 7/ Yrs	. World's Day's Flours	may 12,19	134 South Carpena
	pu 🖢 :	-	Usual Residence of Decedent  10a. State 4 10b. County	10c. City, Town o	Location	- ' '	10d. Inside City Limits
	sho	5	N	A	So Hi		1 Xes 2 □ No
	the N	ecte	10e. Street and Number		10f. Zip Code	10g. C	Citizen of What Country?
	with	ä	2503 W	rankles Sa	F. 21229		1) SA
	ns 23	Funeral Director	11. Marital Status	Was Decedent Ever in U.S.     Armed Forces?	i3. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - American Indian,
(O	or Iter	F	1 Never Married 2 Married	1 ☐ Yes 2 👿 No		Hican, etc.)	Black, White, etc.
03	hours after death with the Maryland tural', or Items 23a or 28a-f show I Examiner must be notified at	β	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2, DYNo Specify:		Specify: Dak
5-0	72 h "natu	ete	15. Decedent's Educ (Specify only highest grade	completed) (G	ecedent's Usual Occupation live kind of work done during most of work	king 16b.	Kind of Business/Industry
21215-0036	e filed within 72 hours after dea it Hygiene. other than "natural", or Items rent, Ite M. dic It Ex. nif et m	Completed by	Elementary/Secondary (0-12)	College (1-4or 5+)	fe. pg NOT use retired)	ا حا	Imestic
	filed Hygie Hygie other I	ပ္	17. Father's Name (First, Middle, Last)	10/4	18. Mother's Nam	ne (First, Middle, Maide	an Surname)
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, I'm Modical Examiner mast he notified at	To Be			Fanc	in the	aman
ΣŽ	12 should be and Mental ris marked c		19a. Informant's Name/Relationship (Type	pe, Print)   19b. N	ailing Address (Street and Number or Rus		
	and 2 fealth a m 27 is		Althea Cromer-P	ierre -daughter 4	2 W, Biddle St	Baeto.	md. 21201
ē,	s 1 ar		20a. Method of Disposition	cometory	sposition (Name of crematory or other place)	Dete 20c.	Location - City or Town, State
E	Page: nent o nnt: If iry or		1 Surial 2 ☐ Cremation 3 ☐ R  4 ☐ Donation 5 ☐ Other (Specify)	- HK bu	HUS 11/2	5/05	Salto, MID
Baltimore,	permit. Pages 1 ar Department of Hea Important: If item any injury or other once.		21. Signature of Funeral Service License	e /	22. Name and Address of Facility	/11	21229
	20729		Jenol	1 Mans	Cary I bricht	/H 270 FV	echiton Ess Balo, My
			23a. Part 1. Enter the disease, or complishock, or heart failure. List only or	e cause on each line.	enter the inode or dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	Muestetic	J'ancreule, C	Lrunoma	Unknown
	/Medical Examiner			Due to (or as a consequence of)			
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	. Due to (or as a consequence of)			
9	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events				
o	be executed ician and burial-transit		resulting in death) Last	Due to (or as a consequence of)			
8760	cate be executed physician and the burial-transi	dical					
9	ing ph	Med	IF FEMALE:				
Вох	eath certific attending p	ian/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death	3 Ectopic pregnancy		23d. Date of delivery  Month Day Year
	The law requires that the death certificate has been signed by the attending I wage 2 should be detached for use as	by Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at time of death 9☐ Unknown	5 Other (specify)		
P.0	that the od by detact	/ Ph	Part II. Other significant conditions cor	tributing to death but not resulting in the	ne underlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death?
Vital Records,	uires t signe	d b	(<	ty pe tension		1 🗆 Yes	2 No 3 Probably 4 Hinknown
OS	w require been sig	lete		Duni		24a. Was an	24b. Were autopsy findings available
Re	The law cate has I page 2 s	Completed				autopsy performed? 1 ☐ Yes 2 2 1	prior to completion of cause of death?
ta	00 m	a	25. Was case referred to medical		26. Place of Dea	th (Check only one)	10 103 22 10
Z	S S 5	To B	examiner? 1 Yes 2 No	lospital: 1   Inpatient 2   ER/Outp	atient 3 DOA Other: 4 Nursing H	ome 5 Residence	6 ☐Other (Specify)
J of	ding Phy After thi funeral		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury 28b. Tin (Month, Day Year) Inju		28d. Describe how in	jury occurred
<u>S</u> i	Attending ir death. ector: After by the funer	catic	2 Accident investigation		M 1 Yes 2 No		
Division	or Att	rtifi	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm building, etc. (Specify)	i, street, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
	pital purs a eral D	Ce	29a. Certifier 1 Certifying Phys	zicien. To the hest of my knowledge	death occurred at the time, date and place	and due to the cause	(s) and manner as stated
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi	Medical Certification:			or investigation, in my opinion, death occu		
_	Fo the Mithin Fo the	Me	29b. Signature and title of certifier	,	29c. License number		Date signed (Month, Day, Year)
			<b>→</b>	Rin	727569		11/21/0)
	6		30. Name and address of person who co	empleted cause of death (Item 23a) (T	D27569 (pe, Print) 1838 Gre	0	00 2000
	,		Men	VIII lemy	1838 Ore	me In	er 14 4168
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) NOV 2 3 20	32. Jegistrar's Signature	Coarles		
	-		MUANOL	MARCHAN DO 1			

State of Maryland / Department of Health and Mental Hygierje Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** VOV David Harry chambers Sr. 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** HOSPITAL ST. AGNES BALTIMORE n/a | If Under 14 Hrs. | 8. Date of Birth (Months Days Hours Min. | 3. Date of Birth (Month, Day, Year) | July, 23, 1 Birthplace (State or Foreign MD 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 13€ M 2 ☐ F Yrs. 84 Director 577-46-9857 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Item 27 is marked other than "naturel", or items 23s or 28s-f show other traumatic event, the Modical Experiencement for multiple at 14 Yes 2 No Director MDBaltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21228 719 Maiden Choice Ln. permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Heelth and Mental Hygiene. Important: If Item 27 Is marked other than "naturel', or Items 23s any injury or other traumatic event, the Madical Exprinter must once. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: white Baltimore, Maryland 21215-0036 1 ☐ Yes 2₺ No Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) USA Government research Chemist 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Rita Marie Pisani David Harry Chambers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 719 Maiden Choice Ln. Catonsville, MD 21228 Jane Nicoll Chambers- wife 20b. Place of Disposition (Name of competery, crematory or other place)
Baltimore Crematory @
Loudon Park 20a. Method of Disposition
1 □ Burial 2 □ Cremation 3 □ Removal from State Date 20c. Location - City or Town, State Nov. 17, 2005 Baltimore City \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Loudon Park Funeral Home 192 3620 Wilkens Ave. Baltimore, MD 21229 23a. Part. Enter the disease, or complications that career the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on electrine. Approximate Interval Between Onset and Death Chronic Obstructive Pulmonary Immediate Cause (Final Disease Stage 4 Physician disease or condition resulting in death) /Medical Examiner Pseudo-Obstruction of the Bowels 1 month Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and s the burial-transit Colon Cancer 4 months Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ Artery Disease 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No Heart 24a. Was an 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 27. Manner of Death 1 Natural Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide within 24 hours aft To the Funerel Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Gaclastro, N.D. Surgical Resident AJ24385283807 November 15, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 Caton Avenue, Baltimore, Mary land Genard De Castro 32: Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar NOV 2 3 2005

**ORIGINAL** 

HAMBERS, DAVID

			r icasc	State of Ma		d / Depa					•	giene	2005	37781	
		-	For State Registrar		•			te of L				Reg. No	000	31101	
			1. Decedent's Name (First, Middle, La.	st)							2. Date of De. Month	ath Da	y Year	3. Time of Death	
	rsicia ledic	al .	Charles Clark								lovembe	r 5	2005	6:45 P. M	
Exa	amine	er	4a. Facility Name (If not institution, giv						Location of	f Death			. County of Dea	ith	
Fund	oral		3408 St. Ambrose  5. Social Security Number 6. S	ex 7 Ans	e (In yrs.	last birthday)	If Unde	timor r 1 Year	If Under 2		8. Date of Bir (Month, Da			thplace (State or Foreign	
Fune Direc			237-30-2804	ØM 2□F		82 Yrs.	Months	Days	Hours	Min.	Month, Da Aug. 21	y Year)	923 Nor	th_Carolina	
pu *			Usual Residence of Decedent  10a. State 10b. County		10c Cit	y, Town or Lo	cation							10d. Inside City Limits	
Aaryla f aho	e De	ō				•								1√ Yes 2 No	
the 1		Director	MD n / 10e. Street and Number	a	L Bal	timore	Cit 10f. Zi	y Code				10g. Cit	tizen of What C	ountry?	
death with the Maryland me 23a or 28e-f ahow	1		3408 St. Ambrose	Ave.				21215					USA		
rdea	100	Funeral	11. Marital Status	12. Was Decedent I Armed Forces?		.S. 13. V	Vas Dece Yes, spe	dent of His	spanic Orig n, Mexican,	in? (Spe Puerto F	cify Yes or No Rican, etc.)	-	14. Race - Am Black, Whi		
-0036 hours after tural, or Ite	dicum	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Tes 2 N If Yes, Give X Year or Dates:	10	1	□ Yes	X2™ No	Specify:	B1ac	k		Specify:	Black	
Iryland 21215-0036 should be filed within 72 hours after death with the Marylar of Mental Hygiene. marked other than "natural", or fleme 23a or 28e-1 ahow	2 22	edk	15. Decedent's E	ducation		16a. Deced	lent's Usu	al Occupa	tion			16b. K	ind of Business	/Industry	
within 72 ene.	Medi	Completed	(Specify only highest gra Elementary/Secondary (0-12)	ade completed) College (1-4or 5	+)	(Give life. L	kind of wi DO NOT i	ork done d ise retired)	uring most	of workin	g				
21 ed wit ygiene ver thu	털	Con	10			Custod	ian					More	lorgan State UN.		
yland 2 ould be filed v Mental Hygie wrked other t	• • • • • • • • • • • • • • • • • • •	Be	17. Father's Name (First, Middle, Last,	1								Maiden Surname)			
Maryland d 2 should be file th and Mental Hy T Is marked othe	matic	၉	Willie Clark  19a. Informant's Name/Relationship (Type, Print)  Elister V. Carter - Daughter  Allnera Hardy  19b. Mailing Address (Street and Number or Rural Route Number, City  3408 St. Ambrose Ave. Baltimore,								ar City o	or Town State	Zin Code)		
M d 2 d 2 d 2 d 4 d 4 d 4 d 4 d 4 d 4 d 4	ige i														
Baltimore, M permit. Pages 1 and 3 Department of Health Importent: If Item 27	othe	Ì	20a. Method of Disposition		20b. F	Place of Dispo	sition (Na	me of			ate		ocation - City or		
Pages Pages nent of ent: If It	ייי פי	'4 Donation 5 Other (Specify) Loudon Park Cemetery Nov. 11, 05 Baltimo									imore (	City			
Balt permit. Departr Importe	eny inju	1	21. Signature of Funeral Service User	1500	_	22	. Name a	nd Addres	s of Facility	Loud	on Par	k Fu	neral H	lome	
T	ā a		BOM NO	nlang	n								laryland		
4/2			23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final		A		Α.			cardiac of	respiratory ai	rest,		Approximate Interval Between Onset and Death	
Fnysic /Medi	_	1	disease or condition resulting in death)	a. Due to (or as	1-50		01	Sease						15 years	
Exami				1-14		4510-									
P. C.		ner	Sequentially list conditions, if any, leading to immediate causs. Enter Underlying Cause (Disease or injury	Due to (or as	a conseq	uence of):									
ecuter	trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	was aft.											
760, te be executed sician and	burial	cal E	Todaming in dodain, said	Due to (or as	a conseq	uence or):									
	s the			_ d	-										
OX (	use a	Z/M	IF FEMALE: 23b, Was decedent pregnant	23c. If yes, outcome	of pregna	ancy	) <b>c</b>						23d. Date of de	livery	
). Box death cer	ad for	sicia	in the past 12 months? 1  Yes 2 No		irth 2 Fetal death 3 Ectopic pregnancy ant at time of death 5 Other (specify)							Month	Day Year		
P.O	etach	Physician/Med	9 🗆 Unknown								one Dida			- the entered of death?	
I Records, P.O. Box 68 The law requires that the death certifica tie has been signed by the attending on	De	þ	Part II. Other significant conditions of	ontributing to death bi	ut not res	uiting in the ur	aderlying	cause give	n in Paπ I.					o the cause of death?	
Vital Records, sician: The law requires the certificate has been signed.	should	Completed								_	24a. Was			utopsy findings available	
Rec he lav	N	dmo									autop	sy rmed?	prior to death?	completion of cause of	
	ō	a	25. Was case referred to medical						26 Place	of Death	1 ☐ Yes		1 LJYes	s 2 □ No	
<u> </u>	direct	0	examiner?	Hospital: 1 ☐ Inpatie	nt 2 🗆	ER/Outpatien	t 3 🗆 D	OA Othe			111111111111111111111111111111111111111		6 □Other (Spe	ecify)	
n of ng Phys fter this	neral	n: T	27. Manner of Death  1 Natural 5 Pending	28a. Date of Injui (Month, Day	ry y Year)	28b. Time of Injury		28c. Injury Work	at ?	2	8d. Describe I	now inju	ry occurred		
VISION Of VITA Attanding Physician: r death.	the tu	catle	2 Accident investigatio 3 Suicide 6 Could not b				М		′es 2□N						
Division of lor Attanding Physafter death. Director: After this	in by	Certification;	4 Homicide determined				et, facto	y, office		2		8f. Location (Street and Number or Rural Route Number, City or Town, State)			
spital ours	pell		29a. Certifier Certifying Pt	nysician: To the best of	of my kno	wledge, death	occurred	at the tim	e, date and	place, a	nd due to the	cause(s	and manner a	s stated.	
Division  To the Hospital or Attanding I within 24 hours after death.  To the Funaral Director: After	completely filled in by the funeral	edical	(Check only 2 Medical Example)	miner: On the basis of and manner sta	examina	tion and/or inv	estigation	n, in my op	inion, death	h occurre	d at the time,	date and	d place, and du	e to the cause(s)	
To th	com	Ž	29b. Signature and title of certifier	) - 0			29	c. License					te signed (Mon		
^			1		M			24	3153			1	1-07-	2005	
1	)		30. Name and address of person who		eath (Iten	1 23a) (Type,	Print)	120 1	rd #	13,-	B41	to	40 3	17 nO	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registra	ar's Signa	iture .	ASC.	M. a		71		- 11		, (0.1	
Re	gistra		NOV 2	3 2005 ▶		1	SOOM	Sand .							

# 05-07779 Allan Culver, Sr. Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of	Marylan	-	artment rtificate			nd Me	ental Hygie	ne . N2 0 0 5	37782
	Physici	3n	1. Decedent's Name (First, Middle, L							2	2. Date of Death Month	Day Ye	3. Time of Death
L	/Medic	al		Alla		ames	Culve				lovember		05 14:11 <sup>™</sup>
7	Examin	er	4a. Facility Name (If not institution, g Johns Hopkins Bay			antan			Location of	Death		4c. County of D	
	Funeral				7. Age (In yrs.		If Under		If Under 2		. Date of Birth	9	Birthplace (State or Foreign
	Director		213-18-6376	1√2 M 2□ F	85	Yrs.	Months	Days	Hours	Min.	(Month, Day, Y	ear)	Country) ryland
	pu s		Usual Residence of Decedent  10a. State 10b. County		10c Cit	ty, Town or Lo	reation						10d leade Ob Livia
	72 hours after death with the Maryland natural', or tteme 23a or 28a-f ehow alest Examination must be notified at	5		timore		,, , , o	Journal	Dun	da1k				10d. Inside City Limits 1 ☐ Yes 2 🏋 No
	28a-	Director	10e. Street and Number	CIMOLO			10f. Zip				100	. Citizen of What	
	th with		7813 Charlesmon	t Poad					212	22		United S	•
	death	Funeral	11. Marital Status	12. Was Dece	dent Ever in U	.S. 13.	Was Deced	lent of His			fy Yes or No- can, etc.)	14. Race - A	merican Indian,
98	or its		1 Never Married 2 Married	1X Yes	2 🗌 No		1 ☐ Yes 2		Specify:	rueito Ni	Call, etc.)		<sup>thite, etc.</sup> White
Ö	hours ture!	ed by	3 Widowed 4 Noivorced	Year or Da	tes:								
7	- × W	Completed	15. Decedent's (Specify only highest g	rade completed)		(Give	dent's Usua kind of wor DO NOT us	il Occupa k done d e retired)	uring most	of working	, 16	b. Kind of Busine Βalt.iπ	iss/industry io <b>re</b> Gas
212	d within giene. r then "	mo.	Elementary/Secondary (0-12) 12 Years	College (1-	4or 5+)		rvice						tric Co.
pu	al Hyg	Be C	17. Father's Name (First, Middle, Las	st)					18. Mother	's Name (	First, Middle, Ma	iden Sumame)	
ylai	Menta Menta arked	2	James Allan C	ulver					Ann	a Arr	nold		
Maryland 21215-0036	s 1 and 2 should be filed within if Health and Mental Hygiene. Item 27 is marked other then other traumatic event, It.a M		19a. Informant's Name/Relationship									City or Town, Stat , Maryla	
e,	1 and Health am 27 ther t		Mr. Allan James 20a. Method of Disposition	culver,	20h F	Place of Disno	sition /Nam	ne of		Dat			
altimore,	permit. Pages 1 Department of H importent: if ites any injury or ott		1 ⊠Burial 2 ☐ Cremation 3		tate	cemetery, crea	matory or ot	her place				c. Location - City	e, Maryland
Ë	artme ortani injury		4 ☐ Donation 5 ☐ Other (Spec 21. Signature of Funeral Service Lic	**	LO	uden P	Name and	d Addres	s of Facility	,			e, maryland
Ba	Dep imp any		Ad 1 Dilles			Ę	uda-R 7922 V	uck Vise	Funer Ave.	al Ho Dun	me of D dalk, Ma	undalk, aryland	Inc. 21222
			23a. Party. En er the disease, or co shock, or heart failure. List on	mplications that ca ly one cause on ea	used the deat ch line.								Approximate Interval Between
12	Physician		Immediate Cause (Final disease or condition	-a atho	coscl	lerch	c Ca	sdi	o Vas	Culc	2 dis	Rase	Onset and Death
	/Medical Examiner		resulting in death)	Due to (d	or as a conseq	uence of):							
		- a	Sequentially list conditions, if any, leading to immediate	juence of):									
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events										
ó	be executed sician and burial-transit		resulting in death) Last	Due to (c	or as a conseq	juence of):							
8760,	ate he he	Ical	•	d									
9 ×	ertifica ling pl	Med	IF FEMALE:										
Вох	eath certific ettending p	lan/	23b. Was decedent pregnant in the past 12 months?		ome of pregna th 2 □Feta int at time of d	ıldeath 3 [	Ectopic pre					23d. Date of Month	delivery Day Year
P.O.	by the datached	Completed by Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unkno		eam 5L	Other (spe	эспу)					
0	es that thighed by	y Pt	Part II. Other significant conditions	contributing to de	ath but not res	ulting in the u	nderlying ca	ause give	n in Part I.		23e. Did toba	cco use contribute	to the cause of death?
rds	v require been sig should b	ed b	Emphy Sema	)							1 🗌 Yes	2 □ No 3 □	Probably 4 Unknown
ဝင္ပ	law requass been 2 should	plet									24a. Was an	24b. Were	autopsy findings available
Ä		mo.									autopsy performe	d? death	
/ita			25.111							of Death (	Check only one)		
of \	cian: ertific actor,	Be	25. Was case referred to medical examiner?										
Ĕ	hysician: Th this certificate al director, pag	To Be	examiner? 1 XYes 2 No			ER/Outpatier			4 ( 1401			ce 6 Other (S	pecify)
	Physician: this certific ral director,	To Be	examiner? 1 XYes 2 No  27. Manner of Death 1 XNatural 5 Pending	28a. Date o		ER/Outpatier 28b. Time o Injury	f 28	Bc. Injury Work	at ?	28	5 Residence d. Describe how		pecify)
isic	ding Physicien: h. After this certific funeral director,	To Be	examiner?  1 XYes 2 No  27. Manner of Death 1 XNatural 5 Pending investigati 3 Suicide 6 Could not	28a. Date o (Month	f Injury D. Day Year)	28b. Time o Injury	f 28	Bc. Injury Work 1 🗆 Y	4 ( 1401	286	d. Describe how	injury occurred	
Division of Vital Records,	ding Physicien: h. After this certific funeral director,	To Be	examiner?  1 Xyes 2 No  27. Manner of Death 1 Xhatural 5 Pending 2 Accident investigati	28a. Date o (Month		28b. Time o Injury	f 28	Bc. Injury Work 1 🗆 Y	at ?	286	d. Describe how	injury occurred	pecify) Rural Route Number,
Division	ding Physicien: h. After this certific funeral director,	Certification; To Be	examiner?  1 Xyes 2 No  27. Manner of Death 1 XNatural 5 Pending investigati 3 Suicide 6 Could not determine  29a. Certifier 1 Certifying P	28a. Date o (Month) be 28e. Place o buildin	f Injury , Day Year) of Injury - At h. g, etc. (Specif	28b. Time o Injury ome, farm, str	M 28 M reet, factory,	Bc. Injury Work 1  Y	at ? Yes 2 N	286 286	d. Describe how  f. Location (Strectity or Town, or due to the cau-	injury occurred  at and Number or State)	Rural Route Number,
Division	ding Physicien: h. After this certific funeral director,	edical Certification; To Be	examiner?  1 Xyes 2 No  27. Manner of Death 1 XNatural 5 Pending investigate 3 Suicide 6 Could not determine  29a. Certifier (Check only one)  1 Certifying 8 2 Medical External	28a. Date o (Month) be 28e. Place buildin	f Injury  of Injury - At h  g, etc. (Specif  best of my kno  sis of examina	28b. Time o Injury ome, farm, str	M 28 M reet, factory, h occurred a vestigation,	Bc. Injury Work 1 Y , office at the time in my op	at 7 7 / es 2 N	286 286	d. Describe how  f. Location (Stre- City or Town, d due to the cau at the time, date	injury occurred  et and Number or State)  se(s) and manner e and place, and of	Rural Route Number, as stated, fue to the cause(s)
Divisio	or Attending Physicien: after death. Director: After this certific in by the funeral director,	Certification; To Be	examiner?  1  Yes 2 No  27. Manner of Death 1  Acident 2  Accident 3  Suicide 6  Could not determine  29a. Certifier	28a. Date o (Month) be 28e. Place o buildin Physician: To the aminer: On the ba	f Injury  of Injury - At h  g, etc. (Specif  best of my kno  sis of examina	28b. Time o Injury ome, farm, str	M 28 M reet, factory, h occurred a vestigation,	Bc. Injury Work  1 T  office  at the time in my op	at ?? /es 2 N	286 286 I place, and	f. Location (Stre- City or Town, and due to the cau- at the time, date	at and Number or State) se(s) and manner or and place, and (Ma	Rural Route Number, as stated, fue to the cause(s)
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	edical Certification; To Be	examiner?  1  Yes 2 No  27. Manner of Death 1  Avatural 5 Pending investigate 3  Suicide 6 Could not determine  29a. Certifier (Check only one)  29b. Signature and title of certifier	28a. Date o (Month) be 28e. Place o buildin Physician: To the barniner: On the barniner and mann	f Injury, Day Year) of Injury - At hing, etc. (Specification of my known of stated.	28b. Time of Injury  ome, farm, str  owledge, deat attion and/or in	M 28 M Peet, factory, h occurred a vestigation, 29c.	Bc. Injury Work  1 T  office  at the time in my op	at 7 7 / es 2 N	286 286 I place, and	f. Location (Stre- City or Town, and due to the cau- at the time, date	injury occurred  et and Number or State)  se(s) and manner e and place, and of	Rural Route Number, as stated, fue to the cause(s)
Division	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	edical Certification; To Be	examiner?  1 Xyes 2 No  27. Manner of Death 1 XNatural 5 Pending investigate 3 Suicide 6 Could not determine  29a. Certifier (Check only one)  1 Certifying 8 2 Medical External	28a. Date o (Month)  28e. Place buildin  Physician: To the aminer: On the ba and mann  o completed cause	f Injury, Day Year) of Injury - At hing, etc. (Specification of my known of stated.	28b. Time of Injury  ome, farm, striction and/or in  m 23a) (Type,	M 26 M 26 M 26 M 26 M 26 M 26 M 26 M 26	Bc. Injury Work 1 Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y	e, date and inion, death	28d 28d 28d 28d 28d 28d 28d 28d 28d 28d	d. Describe how  f. Location (Stre- City or Town,  d due to the cau at the time, date  NC	at and Number or State) se(s) and manner or and place, and (Ma	Aural Route Number,  as stated, fue to the cause(s)  onth, Day, Year)

			For State Registrar	State	of Maryland		rtment of Hea			iene g. No. 0 0 5	37783
İ			Decedent's Name (First, Middle	, Last)					2. Date of Deatl Month		3. Time of Death
	Physicia /Medic			Howard K	evin Cox					er 18,200	
	Examin		4a. Facility Name (If not institution	give street and no	umber)		4b. City, Town, or Loc	cation of Death		4c. County of C	Death
			3125 Sollers Po				Dundal				imore
	Funeral		5. Social Security Number	6. Sex 1 ⊈M 2 ☐ F	7. Age (In yrs. la	ast birthday) Yrs.		Under 24 Hrs. lours Min.	8. Date of Birth (Month, Day,		Birthplace (State or Foreign Country)
	Director		218-58-2623 Usual Residence of Decedent		5.4	113.			Sept. 2	9,1951	Maryland
	ow ow	Ì	10a. State 10b. County		10c. City	, Town or Lo	cation				10d. Inside City Limits
:	Mary Fed sh	ţō	Maryland	Baltimor	e			Dun	dalk		1 □ Yes 2000 No
	n the	Director	10e. Street and Number				10f. Zip Code		10	g. Citizen of Wha	t Country?
	23s c		3125 Sollers	Point Ro	ad		2122			United S	
	ens erm	Funerai	11. Marital Status	Armed F		S. 13. \	Vas Decedent of Hispa f Yes, specify Cuban, N	inic Origin? (Spe Mexican, Puerto	ecify Yes or No- Rican, etc.)		Americen Indian, Vhite, etc.
30	n 72 hours after death with the Maryland "naturel", or frems 23e or 28e-f show edical Examiner must be notified at	by Fu	Never Married 2 Marr 3 Widowed 4 Divorced	If Vac C	2 □ No live		☐ Yes 2√2 No S	pecify:		Specify:	White
5-0036	hour tural		15. Decedent		Dates: Vietn		lent's Usual Occupation	n		16b. Kind of Busin	
Ç LZ	within 72 ene. then net	Completed	(Specify only highes	t grade completed		(Give	kind of work done durin OO NOT use retired)	ng most of worki	ng		o & Back River
212	i with	E	Elementary/Secondary (0-12) 12 Years	College	(1-4or 5+)	Locor	notive Engi	neer		Rail Ro	
	a filed other vent, I	8	17. Father's Name (First, Middle,	Last)			18.	. Mother's Name	(First, Middle, N	Maiden Sumame)	
<u>lar</u>	should be ind Mental in marked or matic eve	To B	Glenn S. Co	OX				Jua	nita E.	Long	
Maryland	ages 1 and 2 should nt of Health and Men I: If item 27 is marke r or other traumatic		19a. Informant's Name/Relations				g Address (Street and				
_	and and a n 27 m 27 ver tr	i) y	Mr. Kenneth L	. Cox (Br			Bushy Tail	_			25427
ore	ges 1		20a. Method of Disposition  1   Burial   Cremation	3 Removal from	n State	emetery, crer	sition (Name of natory or other place)			20c. Location - City	
Ē	. Pages tment of tant: If it jury or o		• 4 □ Donation 5 □ Other (S	oecify)	Hil		Service Cor		5/2005	Towson,	Maryland
Baltimore,	permit. Page Department of Important: If eny injury of		21. Signature of Funeral Service	21	Leel	1	Name and Address of Ouda-Ruck F 7922 Wiser	Tuneral Awe Dunc	lalk, Ma	ryland :	Inc. 21222
P	age .		23a. Part1. Enter the disease, or shock, or heart ailure. List	complications that	caused the death	n. Do not ent	er the mode of dying, s	uch as cardiac o	or respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	Hyp	ertensius	2 Anteri	oscleratic Co	andiovas	cular D	isease	10 years
	/Medical Examiner		resulting in death)		o (or as a consequ						
	zammer	<u>_</u>	Sequentially list conditions, if any, leading to immediate	b. — Due to	o (or as a consequ	ience of):					
14	led nsit	Examiner	Cause (Disease or injury		o (or as a consequ	<b>261106</b> 017.					
_	al-tra	xar	that initiated events resulting in death) Last	c. Due to	o (or as a consequ	uence of):					
760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	icai		d		_					
9	tificat ig phy as th	edi									
Вох	ath certific attending p for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant		utcome of pregna				23d. Date of Month	delivery Day Year	
Э.	death he atte	sici	in the past 12 months?	4□Pre- 9□Uni	gnant at time of de	eath 5	Other (specify)			MOUTH	Day 16a1
P.O.	that the de led by the a detached t	Phy	9 Unknown	na contributing to	doath but not room	ulting in the	ndorhing gauga awan i	o Post I	23a Did tob	acco use contribu	te to the cause of death?
ŝ	ires tha signed d be del	by	Part II. Other significant condition	ans contributing to	death but not rest	anning in the o	noenying cause given i	ii r alic t.			Probably 4 Unknown
Records,	w requir been si should	Completed									
Sec	e law has t	jdr							24a. Was a autops perform	y prioi	e autopsy findings available to completion of cause of h?
a									1 ☐ Yes 2	1 D	Yes 20 No
=======================================	siciar certif recto	Be	25. Was case referred to medical examiner?  1   Yes 2   No	Hoepital:	71	ER/Outpatier	Othor	1000	n (Check only on	e) ence 6 □Other(	Canada)
ot	ding Physician: h. Atter this certific funeral director.	5. To	27. Manner of Death	28a. Dat	e of Injury	28b. Time o				ow injury occurred	эр <b>е</b> спу)
o	ding th: Afte	후	1 Natural 5 ☐ Pendir 2 ☐ Accident investi	9	onth, Day Year)	Injury		2 □ No			
Division of Vital	I or Attending Physician: after death. Director: Atter this certific: I in by the funeral director.	ifica	3 Suicide 6 Could 4 Homicide determ	ined 288. Pla	ce of Injury - At ho		eet, factory, office		28f. Location (St City or Town	reet and Number o	r Rural Route Number,
Ö	F 및 # Q	Certification:	4   Homicide	bui	lding, etc. (Specif)	V)			City of Town	i, State)	
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	Medicai (		Examiner: On the			h occurred at the time, vestigation, in my opini				
	ro th vithin ro th compl	Me	29b. Signature and title of certifie	١ .			29c. License nu	umber	2	9d. Date signed (A	fonth, Day, Year)
•	,- ,- 0	1	[ hardely	I Cum	rtugal		0186	67	0	Vovembe	122,2005
	. 1		20, Tame and address of person	who completed ca	use o death (It	23a) (Type,					(
	671		Prilip Militel	6,MD 6	: Trimble	e Hill	Print) Cit Lu Henvill	e Mary	land 21	993	
		ate	31. Date filed Month, Day, Year,	A	Registrar's Signa	iture					
5	Regist	rair	2 9 1014	2005	1	E Bo	34/23				

ORIGINAL

			_ For	State of Marylan				lental Hyg	iene	0 = 0 = 0
			State Registrar		Cer	tificate of	Death		eg. N6- UU 🧻	3//84
	Physicia	an	Decedent's Name (First, Middle, Last)      Decedent's Name (First, Middle, Last)					2. Date of Deat Month	Day Yea	
	/Medic		Dorothy M. Duke  4a. Facility Name (If not institution, give str.			4h Cih, Tourn o	r Location of Death	Nov. 17	7 <b>.</b> 05 4c. County of De	6:15pm <sup>™</sup>
	Examin	er	201 Harmison St.	eet and number)		Baltin			n/a	odu i
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I	last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,		lirthplace (State or Foreign Country)
	Director		219-32-7851	4 21DF 69	Yrs.	Months Days	Hours Min.	Feb. 23		Maryland
P.	>		Usual Residence of Decedent  10a. State 10b. County	10c Cin	, Town or Lo	cation				10d. Inside City Limits
laryla	if Health and Menial Hygiene. item 27 is marked other than "natural", or items 23e or 28a-f show other traumatic avant, I'm Medical Examinar mual be notified at	5								1, Yes 2 No
the N		ecte	MD n/a  10e. Street and Number	Ba.	ltimore	10f. Zip Code		1	0g. Citizen of What	Country?
with		Ö	201 Harmison			21223	l		USA	•
d 6 16 15-0000 filed within 72 hours after death with the Maryland	ms 2:	by Funeral Director		. Was Decedent Ever in U.	S. 13. V		lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	14. Race - Ar	merican Indian,
after	or Ite	Ē	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give		Tes, specify Cuba	0 "		Black, Wi	
Sours	[8]		3 ☐ Widowed 4 ☐ Divorced	Year or Dates:			WII			white
727	"nat	Completed	15. Decedent's Educa (Specify only highest grade of	tion completed)	(Give	fent's Usual Occup kind of work done DO NOT use retired	during most of work	ing	16b. Kind of Busines	ss/Industry
withir	than	gu	Elementary/Secondary (0-12)	College (1-4or 5+)	Homema		-,		Home	
Del i	Hygi other ant, I	o C	17. Father's Name (First, Middle, Last)		Homema	ikei	18. Mother's Nam	e (First, Middle, M		
should be	ked c	ToB	Joseph Geiler				Theresa	Buckhei	dt	
shou	and M s mar umat	-	19a. Informant's Name/Relationship (Type	Print)	19b. Mailin	g Address (Street	and Number or Run	al Route Number	; City or Town, State	o, Zip Code)
and 2	Health and Mental Hygiene. Iem 27 Is marked other than other traumatic avant, Italia		George D. Burch-	-	_1				aryalnd 2	
Pages 1	Department of Health a Important: If item 27 Is any injury or other tra once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Ren	moval from State	lace of Dispo emetery, cren	sition (Name of natory or other plac	сө)	Date	20c. Location - City	or Town, State
Pag	ment tant: I		'4 □Donation 5 □ Other (Specify)	Lot	idon Pa	ark Cemet	ery Nov.	21, 05	Baltimore	e City
Dall.	Depart Import any in once.		21. Signature of Funeral Service Licensee	Paranel					k Funeral	
			23a, P. 1. Enter the disease, or complica	ations that caused the death					e, MArylaı est	Approximate
			s ock, or heart failure. List only one	cause n each line.	1		_			Interval Between Onset and Death
	nysician Medical		disease or condition resulting in death)	Due to (or as a conseq	CeTIC	Lune	g Can	COL		141
	xaminer			Dee to (or as a conseq.	derice orj.					
		je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseq	uence of):					
cuted	nd transi	Examiner	that initiated events c.			T <sub>a</sub>				
f ou,	ian a urial-l		resulting in death) Last	Due to (or as a conseq	uence of):					
		dical	d.							
OX OQ	ding se as	Physician/Med	IF FEMALE: 230	c. If yes, outcome of pregna	incy				23d. Date of	delivery
death death	atten I for u	clan	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No	1 ☐Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d		Ectopic pregnancy Other (specify)	у		Month	Day Year
<u>غ</u> ز	y the ached	hysi	9 Unknown	9□ Unknown						
ords, r.O	ned t	by P	Part II. Other significant conditions conti	ributing to death but not res	ulting in the u	nderlying cause giv	en in Part I.	23e. Did tol	•	to the cause of death?
aduire	been sig							1 🗆 Ye	es 2□No 3	Probably 4 □Unknown
S (1)	S b	ompleted					<u> </u>	24a. Was a autops	sy prior t	autopsy findings available o completion of cause of
	pag	Con						perform 1 🗆 Yes	med? death 2 No 1 ☐ Y	
OI VITAL	certificate ector, pag	Be	25. Was case referred to medical examiner?	spital:		Ott	200	h (Check only on		441400
O A	this ral dii	. To	1 ☐ Yes 2 No 27. Manner of Death	1 □ Inpatient 2 □	ER/Outpatien	IL 3 DOA	4   Nuising no	-	ence 6 ⊡Other (S ow injury occurred	pecify)
	th. After	tlon	1. Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	Injury		rk? ∣Yes 2 ∐No			
VISION	r dea ector by the	ifica	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he	ome, farm, str	reet, factory, office		28f. Location (St City or Town		Rural Route Number,
בֿ בֿ	s afte	Certification:	4 - Homicide	building, etc. (Specif	y)			0.1, 0, 70.11	., 0.0.0)	
Hospil	within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	edical	29a. Certifier (Check only one) 2 Medical Examina	cian: To the best of my kno er: On the pasis of examina and manner stated.	wiedge, deati tion and/or in	h occurred at the til vestigation, in my o	me, date and place, opinion, death occur	and due to the cared at the time, d	ause(s) and manner ate and place, and c	as stated. lue to the cause(s)
Toth	within To th comp	Me	29b. Signature and title of certifier	. //	\	29c. Licens	se number	2	9d. Date signed (Mo	onth, Day, Year)
	/		I few Lyle	men mi	ر ا	D	18584		Nov 21	2005
	5		30 Name and address of person who com	npleted cause of death (Item	atan	Print) Ave	Bal	timore	Nov 21 Mel	21229
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) / NOV 2 3 20	32. Registrar's Signa	ature A	books				
			1907 7		~					

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Robert Lee Dove Nov 13, 8:20 P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner St. Mary's 26121 Woody Court Mechanicsville If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) Dec 28, 19 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1**∑**M 2□ F Days Hours Yrs. 1945 Director 220 42 2248 59 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits i Hygiene. other than "naturel", or iteme 23a or 28a-f ehow vent, It's Medical Exertiner must be notified at 10b. County 10c. City, Town or Location St. Mary's Mechanicsville 1 Yes 2XXNo Funeral Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20659 United States 26121 Woody Court 12. Was Decedent Ever in U.S. Armed Forces? 1X Xyes 2 □ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 27 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2√XNo Specify: ģ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Service Manager Business Printing permit. Peges 1 and 2 should be filed v. Department of Health and Mental Hygier Important: If Item 27 is marked other tt any injury or other traumatic avent, IIIs 2008. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Sadie Marie Chaney Eldridge Preston Dove 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeanne E. Dove (Wife) 26121 Woody Court, Mechanicsville, MD 20659 20b. Place of Disposition (Name of cemetery, crematory or other place) Nov 17, D2005 20a. Method of Disposition 20c. Location - City or Town, State 1XBurial 2 Cremation 3 Removal from State Clinton, Maryland 4 □ Donation 5 □ Other (Specify) Resurrection Cemetery 21. Signature of Funeral 22. Name and Address of FacilityLee Funeral Home, Inc 6633 014 Alexandria Ferry Rd, Clinton, MD 20735 2001 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** gastric adenocarcinoma disease or condition resulting in death) /Medical Que to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed ettending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) signed by the e 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by di yease 2 No 1 Tes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an 2 No 1 ☐ Yes 24 hours after death.

Funerel Director: After this certification filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ို 1 ☐ Yes 2 No 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Certification; 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) 00055682 attendin: 11/15 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas M. Wilkinson, M.D., 23415 Three North Rd # 2052 California MD 20619 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

		1	State of Maryland / Dep  State of Maryland / Dep  Ragistrar  Ce	artment of Health and rtificate of Death	Mental Hygie	After the site terms							
*	Physicia		1. Decedent's Name (First, Middle, Last)  Leno Ralph Delmolino		2. Date of Death	Day Year 9 2005 07:00pM							
	/Medic Examin		4a. Facility Name (If not institution, give street and number) Holy Cross Hospital	4b. City, Town, or Location of Dea Silver Spring		4c. County of Death Montgomery							
	Funeral Director	-	5. Social Security Number  032-22-3355  6. Sex 1 ★ 7. Age (In yrs. last birthday 7. Age (In yrs	If Under 1 Year   If Under 24 Hr   Months   Days   Hours   Mir									
	nyland show		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L			10d. Inside City Limits 1 ☐ Yes 2 🛣 No							
	Sea-f	Director	MD Montgomery Silver  10e. Street and Number	Spring 10f. Zip Code	100	Citizen of What Country?							
	with I	Dir	2010 Fairland Rd.	20910		USA							
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28a-f show says injury or other traumatic event, Ite Medical Examinating must be multipled at ODGs.	by Funerai	11. Marital Status  1 X Never Married 2 Married 3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No 1942 If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue 1 ☐ Yes 2 ☒ No Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White							
Maryland 21215-0036	ithin 72 hounder.	Completed	(Specify only highest grade completed) (Giv Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation a kind of work done during most of w DO NOT use retired)	orking 168	D. Kind of Business/Industry							
121	iled w Hygier ther th		17. Father's Name (First, Middle, Last)	lesman	ame (First, Middle, Mai	Insurance							
/land	outd be f Mental It arked of atic eve	To Be	Ralph Delmolino	Rose	Colli								
Nar Nar	12 sho h and 7 is m traum			ing Address (Street and Number or F Box 416 Gt. Bat									
altimore, N	1 and Healtl		20a Method of Disposition 20b. Place of Disp	osition (Name of		c. Location - City or Town, State							
	Pages ent of nt: If it ry or c		1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Cemete	matory or other place) Heaven 11-	-23-2005	Silver Spring							
Balti	permit. Departm Imports eny inju		Ceine e e	22. Name and Address of Facility Rapp Funeral & ( 933 Gist Av Silv	Cremation S	ervice MD 20910							
*	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Approximate Interval Betwee Onset and Death of the condition at a second condition and the condition at the cause (Final disease).										
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):  Sensis										
o,	ate be executed thysician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  Pneumonia  Due to (or as a consequence of):										
68760,	ificate by g physic as the bu	edica	d										
P.O. Box	Attanding Physician: The law requires that the death certificate be executed rideath.  ector: After this certificate has been signed by the attending physician and by the tuneral director, page 2 should be detached for use as the burial-transit	Physician/Medical	tF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9  Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 4 Pregnant at time of death 5	23d. Date of delivery Month Day Year									
	uires that I signed by	۵	Part II. Other significant conditions contributing to death but not resulting in the Respiratory Failure	underlying cause given in Part I.		cco use contribute to the cause of death? 2 □ No 3 □ Probably 4 ᡚUnknown							
Division of Vital Records,	The law rec ate has beer page 2 shou	Completed			24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death?  No 1 Yes 2 No							
/ita	ician: Sertific ector,	Be	25. Was case referred to medical examiner?  Hospital: Hospital:	Other	eath (Check only one)								
n of	ing Physical After this cuneral dir	on: To	1 ☐ Yes 2 ☑ No	of 28c. Injury at Work?	Home 5 ☐ Residence 28d. Describe how	e 6 StOther (Specify) HOSPICE injury occurred							
Divisio	i grae	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	M 1 Tyes 2 No	28f. Location (Stree City or Town, S	at and Number or Rural Route Number, State)							
	To the Hospital within 24 hours a To the Funeral I completely filled	edical C	29a. Certifier (Check only one)  15 Certifying Physician: To the best of my knowledge, deal of the deal of examination and/or and manner stated.										
	Fo the within Fo the Somple	Me	29b. Signature and title of certifier	29c. License number	29d.	. Date signed (Month, Day, Year)							
	/- JF 0		I alon the look w.	052261		11-20-05							
	6		30. Name and address of person who completed cause of death (Item 23a) (Type Alan R. Segal MD										
0	Sta Regist		31. Date filed (Month, Day, Year)  32. Bagistrar's Signature	parti									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend items 4a, 10e, 17 per doc/fh 850 12-14-05 vt
State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. N2 0 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day James Bradshaw Durden November 14, 2005 2:49 AM 4a. Facility Name (If not institution, give street and number)
117 Caraway
Road Apt. 2C 4b. City, Town, or Location of Death 4c. County of Death Reisterstown Baltimore County If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | April 12, 1956 5. Social Security Number 7. Age (In yrs. last birthday) Sex XM 2□F 9. Birthplace (State or Foreign 219-60-9914 49 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Baltimore Reisterstown 10e. Street and Number Caraway 10f. Zip Code 10g. Citizen of What Country? -Road Apt. 2C 21136 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify: Specify: 3 Widowed 4 XDivorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Colfege (1-4or 5+) 11th Grade Welder General Dynamics 17. Father's Name (First, Michaelen 18. Mother's Name (First, Middle, Maiden Sumame) John Thomas Anderson Sophia Elizabeth Wendt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Richard Anderson, Sr. 807 Mace Avenue Essex, MD 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) National Cremation Ser. 11/17/05 PLIEXIDINGAR 21. Sign ture of Funeral Service Licensee 22. Name and Address of Facility

**Physician** /Medica Examine To the Hospitel or Attending Physicien: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, < within 24 hours after deati To the Funerel Director; completely filled in by the

Physician

/Medical

**Examiner** 

Director

Funeral

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Be Completed

**Funeral** 

Director

"naturel", or items 23a or 28e-f ehow the Medical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Ē	Elementary/Secondary (0-12)	Colfege (1-4or 5+)	life. DO NOT use retire	ed)							
Be Compl	11th Grade  17. Father's Name (First, Mid <b>Dunds</b> John Thomas Ander		Welder	18. Mother's Name (	First, Middle, Maid		ynamics				
page.  To Be Compl	John Thomas Ander	bon, br.		Sopnia E	lizabeth	Wendt					
10	19a. Informant's Name/Relationship (7		19b. Mailing Address (Stree	t and Number or Rural I	Route Number, Cit	y or Town, State,	Zip Code)				
	John Richard Ande		807 Mace A			1221					
.	20a. Method of Disposition  1	Removal from State	Place of Disposition (Name of cometery, crematory or other pla tional Cremation		20c.	Location - City of					
once	21. Signiture of Funeral Service Licen	see	22. Name and Addr Miller-Dip 6415 Bela								
an :al er	23ar Part 1 Enter the disease, or comp shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)	a. Artenescies on each line.  Due to (or as a consec	the Cardiacascu	ng, such as cardiac or i	respiratory arrest,	212	Approximate Interval Betwee Onset and Dea				
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C										
by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   23c. If yes, outcome of pregnancy 1   Live birth 2   Fetaf death 3   Ectopic pregnancy 4   Pregnant at time of death 5   Other (specify)   Month   Month   Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to										
	Part II. Other significant conditions co	ntributing to death but not res	ulting in the underlying cause giv	ven in Part I.		use contribute to	o the cause of deat robably 4 Hunki				
Completed					24a. Was an autopsy performed?	24b. Were at prior to death?	utopsy findings ava completion of caus				
a a	25. Was case referred to medical examiner?	Hospitaf:	1 04	26. Place of Death (							
ြို	1 X Yes 2 No 27. Manner of Death	I _ Inpatient 2 _	Crootpatient 3 DOA	ner: 4 Nursing Home			cify)				
cation	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury Mo	yat rk? Yes 2 □No	d. Describe how inj	jury occurred					
Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of fnjury - At he building, etc. (Specif.	ome, farm, street, factory, office	Location (Street a City or Town, Sta	and Number or Ru te)	ural Route Number,					
Medical Certification	29a. Certifier (Check only one)	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, death occurred at the til tion and/or investigation, in my o	me, date and place, and pinion, death occurred	I due to the cause( at the time, date a	s) and manner as nd place, and due	s stated. to the cause(s)				
Σ	29b. Signature and title of certifier	1	29c. Licens		29d. D	ate signed (Monti	h, Day, Year)				
	I hiladiculation M	Donatu	1)18	667	1/01	Jomber					

6 Trimble Hill CT. Lutherville, Mary land 21093

DHMH 17 Rev 1/2001

State

Registrar

30. Name and address of person who completed caus of deat (Item 23a) (Type, Print)

32. Registrar's Signature

Philip Militello, MD 31. Date filed (Month, Day, Year)

NOV 2 3 2005

State of Maryland / Department of Health and Mental Hygien 

Certificate of Death

37788

						erunca	ale Oi	Deaiii		Reg. No.		
	Dhysisi	20	1. Decedent's Name (First, Middle, Las		O.E.				2. Date of D Month	Day	Year	3. Time of Death
	Physici /Medi		RUSSELL	E9	OLF				NOVEMS	ER 20,	2005	2115 PM
7	Examir		4a. Facility Name (If not institution, give	street and number)	HUME			4b. City, Town, RANDA	or Location of Dea FLUSTUW		y of Death VTI M	ORE
	Funeral Director		5. Social Security Number 6. Se		e (In yrs. last birthda 82 Yrs	Month	der 1 Year is Days		Hrs. 8. Date of Bi Min. (Month, D Mar 4		9. Birthpla Country MD	ace (State or Foreign y)
			Usual Residence of Decedent									
	ath with the Maryland 23e or 28e-f show ust be notified at	tor	MD 10a. State 10b. County Baltimo	ore	Windson		L				100	d. Inside City Limits 1 ☐ Yes 2 🛣 No
	r 28c	Director	10e. Street end Number			10f.	Zip Code			10g. Citizen of	What Countr	y?
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0	72 hours after death with the Maryland netural', or Items 23e or 28e-f show dical Evamingt must be mutified at	Funeral	11. Marital Status 1 □ Never Married	12. Was Decedent Armed Forces? 1X Yes 2	No				(Specify Yes or Nuerto Rican, etc.)	Bla	ce - America ack, White, et	
02	al', o	δ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	WWII	1 🗆 1 85	2 <b>](</b> ] No	Specify:		Speci	Whit	ie
20	72 ho	ted	15. Decedent's Ed (Specify only highest grad		16a. De	cedent's U	sual Occu	pation during most of	workina	16b. Kind of E	Business/Indu	ıstry
21215-0020	within the the the the the the the the the the	Completed	Elementary/Secondary (0-12)	College (1-4or	0+)	hinis		during most of		Machi	nery	
g	be filed ntal Hygi od other event,	Be (	17. Father's Name (First, Middle, Last)					18. Mother's	Name (First, Middle	a, Maiden Suma	me)	
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Σ	1 and 2 Health a		Mrs. Doris Egolf (	(Spouse)	8327	7 Mino	la1e	Circle	APt. D Wi	indsor M	[i11, M	ID 21244
Baltimore,	ages 1 a ant of Hea it: If item y or othe		20a. Method of Disposition 1 ▼Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify		20b. Place of Dicemetery, of Lake Vie	cremetory o	r other pla		Date 11/26/0	20c. Location Svkesv		
	permit. Pages 1 ar Department of Heal Important: If item 2 any injury or other once.		21. Signature of Funeral Service Licen		4	22. Name HAIGI	and Addr	ess of Facility NERAL H	OME & CHA	APEL, PA	(Вох	
			23a. Part1. Enter the disease, or compshock, or heart failure. List only of	- //-	the death Do not	Sykes	SVILL ode of dv	e, MD Z	1784 (410	))-/95-1 errest		Approximate
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Division of Vital Records,	The law requires thet the deal ste hes been signed by the att page 2 should be detached fo	Completed by							24a. Wa	s en autopsy ormed?	com	e autopsy findings lable prior to pletion of cause eath?
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<b>o</b>	hys this aldi	ျ	1 ☐ Yes 2 ☐ No  27. Manner of Death	1 ☐ Inpatie			DOA	4 La Nursir	ng Home 5 ☐ Res	idence 6 ∐Ot how injury occu		
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ivisio	fter of treed in by	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Inj	ury - At home, farm, c. (Specify)					ation (Street and Number or Rural Route Number, or Town, Stete)		
٢	To the Hospital or Att within 24 hours effer d To the Funeral Direct completely filted in by	edicai Ce		vsician: To the best iner: On the basis o and manner st	f examinetion and/or							
	To the within To the	Me	29b. Signature end title of certifier	lun	la	1	29c. Licen	se number	3	29d. Date sign	ed (Month, D	ay, Year)
	6		30. Neme and address of person who c		leeth (Item 23a) (Ty	pe, Print)	ANI	PALUT	3	MD21	7133	,
	Sta	ite	31. Dete filed (Month, Day, Year)		ar's Signature	,						

Registrar

DHMH 17 Rev 1/2001

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NOVEMBER 16,

VICTORIA ESPIE

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Deeth 1. Decedent's Name (First, Middle, Last) Month Physician 2005 Elahi 100 /Medical 4b. City, Town, or Location of Deeth 4a Fecility Neme (If not institution, give street and number) 4c. County of Deeth Examiner olumsi9 70492 toward If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1□ M 2 F Hours Yrs Director 218-47-8524 August 29, 1937 **Pakistan** Usual Residence of Decedent Pages 1 and 2 should be filad within 72 hours aftar death with the Maryland ent of Health and Mantal Hygiena. 10a. Stete 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director 7 is marked other than "natural", or items 23s or 28s-f traumatic event, the Medical Examiner must be notitle Maryland Howard Columbia 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 21044 U.S.A. by Funeral 5973 Turnabout Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces 11. Maritel Status 1 Yes 27 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1□ Yes 2X No Baltimore, Maryland 21215-0020 Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Pakistan Be Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiena. Education Elementary/Secondary (0-12) College (1-4or 5+) Principal of Primary school Department of Health and Mantal Hygis Important: if Itam 27 is marked other any injury or other traumatic event, # 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Karim Bibi Sirai Gill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5505 Cedar Lane Columbia, Maryland 21044 Mrs. Rizwana Khurram Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Dother (Specify) 11/19/2005 Laurel, Maryland Maryland National Cemetery 21. Signature of Funer V Service Licens 22. Name and Address of Facility Slack Funeral Home, P.A 140053 3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, mock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician myocardia /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Medical Certification: To Be Completed by Physician/Medical Examiner To the Funeral Diractor: After this certificate has been signed by the attending physician and completaly iilled in by the funeral director, page 2 should ba detached for use as the bunal-transit or Attanding Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Division of Vital Records, P.O. Box 68760, Due to (or as e consequence of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown espirators failure 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? After this certificate has TLIYOS ZIONO 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 P/Outpatient 3 DOA 28c. Injury at Work? 27. Menner of Deeth 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury 28d. Describe how injury occurred 5 Pending investigation 1-BNaturel after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 | Homicide To the Hospital within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certified 29c. License number 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) Gary Kazlow MD 10805 Hickory 31. Dete filed (Month, Day, Year) State NOV 2 3 2005 Registrar

			1 - For State	State of Maryland	•	tment of H		, ,	2000	27701
			Registrar  1. Decedent's Name (First, Middle, Last,	)	00111	neate or E	Jean	2. Date of Deat		3. Time of Death
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	/Medi Examir		4a. Facility Name (If not institution, give	street and number)	4		Location of Death		4c. County of Dea	ath
			Interstate 495 near	r Cabin John Pa	rkway	Potor	mac		Montgom	ery
W	Funeral		5. Social Security Number 6. Sec		1	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Vaar)	rthplace (State or Foreign ountry)
	Director		Usual Residence of Decedent	M 20 F 23	Yrs.			8-19-1	982	m G
	/łand		10a. State 10b. County	10c. City, 1	Town or Loca	tion				10d. Inside City Limits
	Mar.	ţċ	ME	mo	ntic	ello				1 Yes 2 No
	th the	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What C	ountry?
	23a 23a	rai	US HWY 1			0470	5O		USA	
	ar deg	Funerai		12. Was Decedent Ever in U.S. Armed Forces?	13. Wa	s Decedent of Hi es, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh	
36	72 hours after death with the Maryland natural', or Items 23a or 28a-f show Jical Exacul ar Loust be incitified at	by F	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	10	Yes 2 No	Specify:		Specify:	white
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Maryland	d Mental marked c	2		-lewelling	11		Paula (	Young)	Flewell	ng
Mai	ges 1 and 2 should it of Health and Mer if Item 27 is marke or other traumatic	n i	19a. Informant's Name/Relationship (Ty	111	19b. Mailing	Address (Street a	¥ .	ALCELLO	City or Town, State,	Zip Cătle)
	s 1 and 7 f Health Item 27 other tr		20a. Method of Disposition	welling JK	e of Dispositi	on (Name of		7 -	NG OF 20c. Location - City o	Town, State
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			23a. Party. Enter the disease or compleshook, or heart failure. List only or	cations that caused the death, ne cause on each line.	Do not enter	he mode of dying				Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Multiple	14	juvié.				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequer	nce of): (					
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9		Aedi	IS SELVING			a commence	- ***	7.		
Вох	death certific e attending p id for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de		topic pregnancy			23d. Date of de	•
0.	0 0	/sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of deat 9☐ Unknown	h 5□0	ther (specify)			Month	Day Year
Ω.	that the de led by the detached	Ph	Part II. Other significant conditions cor	ntributing to death but not resulti-	na in the unde	riving cause give	en in Part I	23e Did tob	acco use contribute t	o the cause of death?
of Vital Records,	es be	d by				mying saasa gira	ar iir i care i,	1 □ Ye		robably 4 Unknown
CO	w requii been s should	ete						24a. Was ar		utopsy findings available
Re	The lavelete has	ompieted						autopsy	prior to death?	completion of cause of
ta		e C	25. Was case referred to medical	6:5:			26. Place of Death	7	No Yes	3 2 □ No
<b>1</b>		To B	examiner? 1 ☑ Yes 2 ☐ No	fospital: 1 ☐ Inpatient 2 ☐ ER	VOutpatient	3□ DOA Othe	-	me 5 Reside		at scene
0			27. Manner of Death 1 ☐Natural 5 ☐ Pending	28a. Date of Injury 28 (Month, Day Year)	Bb. Time of Injury	28c. Injury Work	at		w injury occurred	10/1/50-
sio	ten leat tor: the	catl	2 Accident investigation 3 ☐ Suicide 6 ☐ Could not be	11/16/05	4.39		res 2 □No 🎵			ofer rehicle
Division	or Attendated after deatl	Certification:	4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	s, farm, street Style 1			City or Town		
	pital ours a heral filled		29a. Certifier 1☐ Certifying Phys	sician: To the best of my knowle				Histore 4		esc, MD
	e Fur	edical	(Check only 2 Medical Examinate)	ner: On the basis of examination and manner stated.	and/or inves	tigation, in my op	inion, death occurr	ed at the time, da	ite and place, and du	o to the cause(s)
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Me	29b. Signature and title of certifier	-1-1		29c. License	number	29	d. Date signed (Mon	h, Dey, Year)
			Celvula	XAR!		o.c.	M.E.	N	ovember 17	, 2005
			30. Name and address of person who co	mpleted cause of death (Item 20	3a) (Type, Pri	nt)				
e l			CAPILLIAH	174		enn Stre	et, Balt	imore, M	aryland 21	201
	Sta Registi		31. Date filed (Month, Day, Year)  NOV 2 3 200	32. Begistrar's Signature	Ana	Blue				
	The state of the s	-	NEW Z 3 ZUU	J AND SALA AND	A STATE OF THE STA	07.3				

			1 - For State Registrar	State	of Marylar		artmen <i>rtificati</i>				lental Hy	gien	$\cap$ $\cap$	5	37792	)
. 35	Physici	an	1. Decedent's Name (First, Middle								2. Date of De Month	eath Da	ıy	Yeer	3. Time of Death	1
	/Media	cal	Mary		nes	<del> </del>		lls			Novembe				3:25 P	М
*	Examir	ier	4a. Facility Name (If not institution		umber)				Location of	of Death			County o			
	Funeral		7231 Martell Ave	6. Sex	7. Age (In yrs.	last birthday)	If Under		If Under :	24 Hrs.	8. Date of Bir	rth	altin	9. Birtho	lace (State or Fore	ign
	Director		220-22-3495	1 □ M 2 💢 F	8	Yrs.	Months	Days	Hours	Min.	July 2	8, 19	22	Coun	ginia	,
	and		Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation							1	0d. Inside City Lim	its
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	r 28a	irec	10e. Street and Number				10f. Zip	Code				10g. Ci	tizen of Wi	hat Coun	try?	
	th wit	Funeral Director	7231 Martell Ave	enue				2122	2			U	SA			
	teme	uner	11. Marital Status	Armed F		J.S. 13.	Was Deced	lent of His	spanic Orig	gin? (Spe	ecify Yes or No Rican, etc.)	)-	14. Race Black	- Americ White,		
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ore,	Heim Heim Sthe		20a. Method of Disposition 1	3 Removal from	State	Place of Dispo cemetery, crei	natory or o	ther place			ember		ocation - C			-
Baltimore,	permit. Pages Department of Important: If it any injury or o		4 ☐Donation 5 ☐ Other (Sp	ecify)	HoL	ly Hill I			aB	26,	2005		ile R		, MD	
Ba	Depa Impo any i	Į,	21. Signature of Funeral Service I	Cdt (	onne	My 7	<u>110 S</u>	olle	rs Po	int_	me Of I Road, I	Dund	alk,F alk,M	A. id. 2	1222	
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Divisi	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fo	Certification:	3 Suicide 6 Could n 4 Homicide determi	ot be 28e. Plac	e of Injury - At hi ling, etc. (Specil	ome, farm, str y)	eet, factory	office		2	8f. Location (S City or Tox	Street an vn, State	d Number	or Rural	Route Number,	
	ne Hospil n 24 hour he Funer	edicai	29a. Certifier 1 Certifying (Check only one) 1 Medical E	Physicien: To the k examiner: On the to and man	e best of my kno basis of examina nner stated.	owledge, death	occurred a vestigation,	at the time in my opi	e, date and nion, deatl	d place, a h occurre	nd due to the end at the time,	cause(s) date and	and mann place, and	er as sta d due to	ited. the cause(s)	
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6	)		30. Name, and address of person v	no completed cau		n 23a) (Type,	Print)	0	0 - 1	11. 1	Wa B					_
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	Registr		NOV 2 3	2005	CARON 1	O AP										

			1 - For State Registrar	ate of Marylan	d / Depa <i>Cei</i>	artment of H rtificate of L	ealth and N Death		005	37793
	Physici /Medi		1. Decedent's Name (First, Middle_Last)	FRE	Ey			2. Date of Death Month NWEMBE		3. Time of Death
	Examir		4a. Facility Name (If not institution, give stree			4b. City, Town, or	Location of Death		4c. County of Death	
			Hebrew Home of Great				ville		Montgome	ry
	Funeral Director		5. Social Security Number 6. Sex 090−14−6797 1□ M	7. Age (In yrs. I	Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Y	gear) 9. Birth Co. Germ	place (State or Foreign Intry) any
	land ow		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or La	cation				10d. Inside City Limits
	Mary a-f sh ified	tor	NJ Ocean			Jackson				1 ☐ Yes 2 ☐ No
	or 28	lred	10e. Street and Number			10f. Zip Code	<del></del>	109	. Citizen of What Cou	intry?
	ath w	ral	164 Wild Dunes Way			08527			USA	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or items 23e or 28e-f show eny injury or other traumatic event, the Medical Exameter Fullified elongs.	by Funeral Director	1 Never Married 2 Married 1	/as Decedent Ever in U.5 med Forces? □ Yes 2 ☑No Yes, Give ear or Dates:		Vas Decedent of His f Yes, specify Cubar I ☐ Yes 2☐ No	spanic Origin? (Sp. n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify: Wh	
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Mar	12 sh h and 7 Is m raum	1 1	19a. Informant's Name/Relationship (Type, P						ity or Town, State, Zip	Code)
	1 and Healt tem 2		Mrs. Susan Morbach / I	20b. Pl	ace of Dispo	ild Dunes	1		c. Location - City or To	Own State
<u></u>	ages ent of ht: If it y or c		1 X Burial 2 ☐ Cremation 3 X Remove 4 ☐ Donation 5 ☐ Other (Specify)	ral from State	emetery, cren	atory or other place k Cemeter	)		Paramus, N	
Baltimore,	permit. I Departm Importer eny injui		21. Signature of Funeral Service Licensee	11-	ff	ATCHTO FUN	EŔĀĽ <sup>lity</sup> HOMI	E & CHAPE	L, PA (Box	
			23a. Part1. Enter the disease, or complication	ns that caused the death.	. Do not ente	ykesville er the mode of dying	, MD 21/8 , such as cardiac	34 (410)- or respiratory arrest	795–1400	Approximate
	- Pnysician i		shock, or heart failure. List only one cal Immediate Cause (Final disease or condition	Ise on each line.	D					Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or a a consequ	ence of):	0 (1)	-10-11	·/		
	Examiner	e.	Sequentially list conditions, b.	SEOVIL	10	DOMO	ENTIK.	7		
	ted nsit		cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	ence org.					
<u></u>	execu in and ial-tra	Examin	that initiated events c c	Due to (or as a consequ	ence of):					
8/PU	icate be executed physician and s the burial-transit	dlcal	d							
$\sim$	entifica ing pt e as ti		IF FEMALE:							
C. Box	taw requires that the death certificate been signed by the attending to should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	yes, outcome of pregnan □Live birth 2 □ Fetal □Pregnant at time of dea □ Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ery Day Year
ŗ.	that the by detact		Part II. Other significant conditions contribut	ing to death but not resul	Iting in the un	derlying cause giver	n in Part I.	23e. Did tobac	co use contribute to the	ne cause of death?
cords	w requires that the de been signed by the should be detached	ted by						1 ☐ Yes		. /
Ē	The ate has page	Completed						24a. Was an autopsy performed	prior to condeath?	psy findings available impletion of cause of 211 No
VIII	ding Physicien: n. After this certifications of the director.	Be (	25. Was case referred to medical examiner?				26. Pla of Death			
5	Physical direction	- To	1 ☐ Yes 2 No Hospiti	1   Inpatient 2   E	R/Outpatient		4 Nursing Hor		e 6 □Other (Specify	1)
5	fte fte	tlon:	1 V Natural 5 Pending 2 Accident investigation	(Month, Day Year)	28b. Time of Injury	28c. Injury a Work? M 1 ☐ Ye	at es 2 □No	8d. Describe how i	njury occurred	
IVISION	Attence r death	ertificati	3 Suiside 6 Could not be	e. Place of Injury - At hon	ne, farm, stre			8f. Location (Stree	t and Number or Rura	I Route Number,
5	tel or	Cert	4   Hornicide	building, etc. (Specify)				City or Town, S	tate)	
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: Atter completely filled in by the fune	edical	29a. Certifier 1 Certifying Physician (Check only one) 2 Medical Examiner: Call	To the best of my know in the basis of examination and manner stated.	rledge, death on and/or inv	occurred at the time estigation, in my opin	, date and place, a nion, death occurre	and due to the caused at the time, date	e(s) and manner as st and place, and due to	ated. the cause(s)
	To the To the comp	M	29b. Signature and title of certifier	Leloner	y H.D.	29c. License	35436	29d.	Date signed (Month, I)	Day, Year)
			30. Name and address of person who complete	ed cause of deat	23a) (Typerf	rint) LUI	UE.	MD 2	NEMBER Z OSTZ	
	Sta	te	31. Date filed (Month, Day, Year)	32. egistrar's Signatu	ve /		/	102.6	1072	-
	Registra	-	NOV 2 3 2005	Same A	A Age	MEL				

1- For Amend Items 25,26,27,29a per Dr. 123/05dhb

State of Maryland / Department of Health and Mental Hygiene
Per Begistrar

State of Maryland / Department of Health and Mental Hygiene
Per Begistrar

Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Eva Fussell King November 6, 2005 10:15am <sup>™</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Beverly Healthcare Center Frederick Frederick If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 8. Date of Birth (Month, Day, Year) 1 □ M 2 T F Months Days Hours Min. Yrs. Director 81 235-28-8752 May 6, 1924 West Virginia Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show traumatic event, the Medical Exercities must be notified at 1 No 2 No Directo Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ or Items 23a death v Funeral 110 Burgess Hill Way 21702 U.S.A.12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ZNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 2 No Specify: à Specify: 3 XWidowed 4 □ Divorced White netural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 +4 Administrative Health Care marked other and of Health and Mental Hy t: If item 27 Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should William King Lessie Gothard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Kligerman (Daughter) 1359 W. Orchard Rd. Mercersburg, PA 17236 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State November 8, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or once. ŏ 4 □ Donation 5 □ Other (Specify) Smithsburg Crematory 2005 Smithsburg, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility J.L. Davis Funeral Home Mo14/4 | 12525 Bradbury Ave. Smithsburg, Maryland 21783 LAVIS Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause op each line. Approximate Interval Between Onset and Death Immediate Cause (Final Enysician NEUMONIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner IHRIVE . FAILURE 10 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and the burial-transit death certificate be executed Due to (or as a consequence of): 68760 Physician/Medical attending Box IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? res 2 No certificate 1 🗌 Yes 1 ☐ Yes 2 ☐ No of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 2 1 Yes No this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1X Natural 5 Pending after death. 1 Tes 2 No investigation 2 Accident 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide filled within 24 hours a To the Funerel I K Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) > lum D47951 November 7, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sibte A. Kazmi, M.D., 814 Tollhouse Avenue, Frederick, Maryland 21701 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 3 2005 Registrar

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State of Maryland	/ Department of He	ealth and Menta	I Hygiene UU

^			For	State of Marylan				Mental Hyg	iene 0	37795
			State Registrer		Ce	rtificate of	Death	1	eg. No.	
	Physici /Media	cal	1. Decedent's Name (First, Middle, Last JEANET TE	M	GRA	ant_			Day 1BER	Year 3. Time of Death 7, 2005 [1:55 Am
	Examir	ner	4a. Facility Name (If not institution, give		0-		r Location of Deatl	_	4c. Count	y of Death N/A
	Funeral		HARBOR HOSPITAC	ex 7. Age (In yrs.		If Under 1 Year	ORE M	8. Date of Birth		9. Birthplace (State or Foreign
	Director		217-24-5409 1 Usual Residence of Decedent	□M 202 F 75	Yrs.	Months Days	Hours Min.	8. Date of Birth June 049	<b>, 19</b> 30	Mary Tand
	Marylan a-f ehow	tor	10a. State   10b. County   Maryland   Anne An		y, Town or Lo Ba1	cation timore				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	h with the	Funeral Directo	10e. Street and Number 7919 Sea Breeze Di	rive		10f. Zip Code 212	.26	1	0g. Citizen of	Whal Country?
980	be filed within 72 hours after death with the Maryland tal Hyglene. Id other than "natural", or items 23a or 28a-f ehow event, the Mudical Exeminal mail to natified at	by	11. Marital Status  1 Never Married 2 Married  3 W Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1	Was Decedent of Hif Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)		ce - American Indian, ck, White, etc. White
21215-0036	ithin 72 ho ne. Nen "natur Medical	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	lucation de completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired	nation during most of wor d)	king		dusiness/Industry
	be filed ital Hygi id other event, I	To Be Cor	11 17. Father's Name (First, Middle, Last) Charles Parks	0	Но	memaker		ne (First, Middle, M n Miller	Hon Maiden Sumar	
Maryland	nd 2 should be lith and Menta 27 is marked r traumatic ev	Ĕ	19a. Informant's Name/Relationship (7)  Kathy Schaeffer (	Type, Print) Law)		ng Address <i>(Street</i>	and Number or Ru	ral Route Number		, State, Zip Code)
Baltimore,	permit. Pages 1 and 2 should Department of Health and Mer Important; if Item 27 is marke eny injury or other traumatic ong.e.		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specify	20b. P	lace of Dispo	esition (Name of matory or other place en Mem. P	ce)	Date :	20c. Location	-City or Town, State
Balti	permit. Departm Importa eny inju		21. Signature of Funeral Service Licen		1-1					Maryland 21225
	Physician /Medical Examiner pruisi-Itansii	Examiner	23a. Ant1. Enter the disease, or complete the complete th	b. Due to (or as a consequence.  Due to (or as a consequence.	uence of):	er the mode of dyin		or respiratory arre	-	Approximate Interval Between Onset and Death DRYS UNKNOWN
Box 68/60,	death certificate be e attending physicie d for use as the bur	cal	IF FEMALE: 23b. Was decedent pregnant	d					23d Da	te of delivery
o;		Physician/Med	in the past 12 months? 1 □ Yes 2 N No 9 □ Unknown	1∏Live birth 2 ∏Fetal 4∏Pregnant at time of de 9∏Unknown		Ectopic pregnancy Other (specify)				onth Day Year
Records, P	w requires that the been signed by th should be detache	þ	Part II. Other significant conditions co	ontributing to death but not resu	ulting in the u	nderlying cause give	en in Part I.	23e. Did tob	1	ribule to the cause of death?  3 Probably 4 Unknown
-	The law ete has b page 2 sl	Completed						24a. Was ar autopsy perform 1 ☐ Yes 2	red?	Were autopsy findings available prior to completion of cause of death?  1 Yes 2 XNo
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	Phy this raid	n: To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Injury	ER/Outpatien 28b. Time of	1 3LI DOA	4 Li Nursing n	ome 5 Reside		
0	Attending F r death. ector: After by the funera	atlo	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		<br Yes 2 □No			
=	Dir	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, str	eet, factory, office		28f. Location (Str. City or Town	eet and Numb State)	er or Rural Route Number,
	Fru P	Medical (	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exemple)	vsicien: To the best of my knowiner: On the basis of examinat and manner stated.	wledge, death tion and/or inv	occurred at the time vestigation, in my of	ne, date and place, pinion, death occur	and due to the ca red at the time, da	use(s) and ma te and place,	anner as stated. and due to the cause(s)
	To the within 2 To the complei	Σ	29b. Signature and title of certifier	0		29c. License	number	29	d. Date signe	d (Month, Day, Year)
	A		Thack Vanns	MO LLOUSE	OFFIC	FR RE	5000	N	OVEME	3ER 17, 2005
	6		30. Name and address of person who o			Print) 2 St. BA	1751100	= U-	212	ing
B	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signal	ture	4	CHPION	FID	010	
	Registr	ar	NOV 2 3	2005	10	18 10				

		State     Registrar  1. Decedent's Name (First, Middle, Last,		Certificate of		Reg. I	2005	37796 3. Time of Death
Physicia /Medic Examin	al	Frank Griffin  4a. Facility Name (If not institution, give	street and number)		r Location of Death	Nov. 18	c. County of Death	3:30P.
Funeral irector		019 00 1101	7. Age (In yrs. last birt		Hours Min.	8. Date of Birth (Month, Day, Yea		place (State or Foreig
a-f show	ctor	Usual Residence of Decedent  10a. State 10b. County  Maryland Balt	imore Owing	or Location ys Mills				10d. Inside City Limit
23a or 28 nat be no	Funeral Director	10e. Street and Number 9525 Meadows Far	ms Drive	10f. Zip Code 211	17		itizen of What Cou JSA	ntry?
ai', or items Examiner for	by	11. Marital Status  1 □ Never Married 2 □ Married  32 Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? NG Ses 2 □ No WW 2 If Yes, Give Year or Dates:	13. Was Decedent of Hif Yes, specify Cuba	lispanic Origin? (Spec an, Mexican, Puerto F Specify:	cify Yes or No- lican, etc.)	14. Race - Americ Black, White, Specify:Blac	etc.
un kinian rugjano. marked other than 'natural', or items 23a or 28a-f show imatic event, <u>tra Modical Examinar mast be notified al</u>	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 5th grade	e completed)  College (1-4or 5+)	Decedent's Usual Occup (Give kind of work done life. DO NOT use retired	ation during most of workin d)	9	Kind of Business/In	•
narked other	To Be C	17. Father's Name (First, Middle, Last) Phillip Griffin			Ella I	(First, Middle, Maide Egister		
27 is		19a. Informant's Name/Relationship (Ty Jimmy Griffin/S	Son 95.	Mailing Address (Street 25 Meadows	s Farms I	Or. Owin	gs Mills	s, Maryl
important: If item any injury or other once.		20a. Method of Disposition    Burial 2		Disposition (Name of y, crematory or other place on Forest	ss of Facility Cha	n. Owi tman-Ha:	ris Fun	ls, Mary eral Ho
sician edical aminer	-	23a. Part 1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the death. Do n	ot enter the mode of dyin	ig, such as cardiac or			Approximate Interval Between Onset and Death
sicie bul	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Ener underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence o					
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	hysician/Med	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	4 Pregnant at time of death	5 Other (specify)				Day Year
gned by the be detached	by Physici	in the past 12 months?  1 Yes 2 No	4□Pregnant at time of death 9□Unknown	5 Other (specify)	en in Part I.		use contribute to th	e cause of death?
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ete has been signed by the page 2 should be detached	To Be Completed by Physic	in the past 12 months?  1  Yes 2 No 9 Unknown  Part II. Other significant conditions con  Ty 2  25. Was case referred to medical examiner? 1 Yes 2 No	4 Pregnant at time of death 9 Unknown  Itributing to death but not resulting in  ∠⟩ ← ← ← ←	5 ☐ Other (specify)  the underlying cause give	26. Place of Death   er: 4 ☐ Nursing Hom	24a. Was an autopsy performed? 1  Yes 2  N Check only one	use contribute to the Section 24b. Were autoprior to condeath?  1   Yes	ne cause of death?  ably 4 Unknown  osy findings available  npletion of cause of  2 No
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ne Funeral Director: After this certificate has been signed by the pletely filled in by the funeral director, page 2 should be detached	edical Certification; To Be Completed by Physici	in the past 12 months?  1	ad Pregnant at time of death g Unknown  Inhouting to death but not resulting in  ad ∫ ← ← ← ←  Ospital: 1 Inpatient 2 ER/Out 28a. Date of Injury (Month, Day Year)  28b. Tile 28e. Place of Injury - At home, fare building, etc. (Specify)  icician: To the best of my knowledge, ter: On the basis of examination and and manner stated.	the underlying cause given the underlying cause given the underlying cause given the underlying cause given the underlying cause given the underlying also cause given the underlying and the underlying	26. Place of Death  Br: 4 Nursing Hom  At 28  Yes 2 No  28  The, date and place, and place, and place and	24a. Was an autopsy performed? 1 Yes 2 N Check only one  8 5 Residence Id. Describe how inj If. Location (Street a City or Town, Sta	use contribute to the 24b. Were autoprior to cordeath?  1   Yes  6   Other (Specify and Number or Rurale)  s) and manner as std place, and due to atte signed (Month, 1)	ne cause of death?  ably 4 Unknown  asy findings available inpletion of cause of 2 No  Poute Number,  ated, the cause(s)  Day, Year)

		State Offperid Tellin Registrar  1. Decedent's Name (First, Middle, La		epartment of Health an ne G850 12-2-05 ta Certificate of Death	Reg.	2005	3 7 7 9  3. Time of Deat
Physic /Medi		Joel E.	Gilkerson		Month	Day Year 16, 2005	2:05P.
Exami	444	4a. Facility Name (If not institution, giv		4b. City, Town, or Location of D	eath	4c. County of Death	
Funeral	- 4	HARBOR HOSPITAL C 5. Social Security Number 6. S			Hrs. 8. Date of Birth	N/A 9. Birthpla	ace (State or For
Director		217-04-0242	1XM 2□F 43 Y	rs. Months Days Hours	Jan. 04	1962 Count	MD MD
A 11		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town	or Location		10	d. Inside City Lin
r 28a-f show	to	Maryland Anne A	rundel	Glen Burni	e		1 ☐ Yes 2 🛛
or 28s	Director	10e. Street and Number		10f. Zip Code		Citizen of What Count	ry?
s 23s		1757 Marley Ave		21060	2/0	USA	- Indian
al, or items Examinar m	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 XDivorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin' If Yes, specify Cuban, Mexican, P     □ Yes 2 No Specify:	? (Specify Yes or No- uerto Rican, etc.)	14. Race - America Black, White, e Specify: Whi	tc.
"natural", adical Exp	Completed	15. Decedent's E (Specify only highest gra	ducation 16a.	Decedent's Usual Occupation (Give kind of work done during most of	working 16b	. Kind of Business/Indi	ustry
then then	Jd III	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retired) Painter		Constructio	nn.
other snt.	Be Co	17. Father's Name (First, Middle, Last	)		Name (First, Middle, Maid		711
Menta rrked rtic ev	To B	Jerry Gil	kerson	Lec	la Mallor	ry	
is ma		19a. Informant's Name/Relationship	** *	Mailing Address (Street and Number of			Code)
Health am 27 ther t		Carol L. Gilkers	141-15	22 east Maple Road	120	Location - City or Tov	vn State
ant of at: If it y or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Sec.i	Removal from State cemetery	, aramatan, ar athar alasa)	v 22	ltimore, M	
Department of Health and Mental Hygiene. Important: if itam 27 is marked other then "nu any injury or other traumatic event, the Mealt once.		21. Signature of Funeral Serv ce Lice		22. Name and Address of Facility 3111 Mountain F	Stallings	Funeral H	ome, P.
y Sphysician and Medical saminer samin	edical Examiner	fmmediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, the cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Narcotic Intoxic  Due to (or as a consequence of the consequence of	rt):			Onset and Deal
by the attending I lached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetaf death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 Ectopic pregnancy 5 Other (specify)		23d. Date of deliver Month D	y Day Year
n signed ald be de	Ď	Part II. Other significant conditions	contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobacc	co use contribute to the	cause of death
icate has bee ., page 2 shoi	Completed				24a. Was an autopsy performed 1 Yes 2	? le th?	sy findings avai pletion of cause
is certificat director, pa	o Be	25. Was case referred to medical examiner?  1 ∑ Yes 2 □ No	Hospital: 1 ☐ Inpatient 2 🔀 ER/Out		Death Check only one one of the control of the one of t	6 Other (Specify)	
fter th	Certification: T	27. Manner of Death  1 Natural 5 Pending 2 Accident investigatio	28a. Date of fnjury Found Day Year) 11-16-05  28b. Ti Found 11-16-25	me of 28c. Injury at Work?  1 □ Yes 2▼ No	28d. Describe how in	njury occurred	unk
within 24 hours after death.  To the Funeral Director: A completely filled in by the fu		3 Suicide 64 Could not be determined	28e. Place of Injury - At home, far building, etc. (Specify)	m, street, factory, office unk	28f. Location (Street City or Town, St Glen Burni	and Number of White ate) 6640 White e, Marylan	d tmore C
24 hou Fune stely fil	Medical	29a. Certifier (Check only one)  1 Certifying Pl 2 Medical Example one)	nysician: To the best of my knowledge, miner: On the basis of examination and and manner stated.	death occurred at the time, date and place to the death of the stigation, in my opinion, death of	lace, and due to the cause occurred at the time, date a	(s) and manner as sta and place, and due to t	ted. he cause(s)
within 2 To the I complet	Mec	29b. Signature and title of certifier	and mailing stated.	29c. License number	29d. I	Date signed (Month, D	ay, Year)
7 - 0		1/abril	in sel	O.C.M.E.	NOV	EMBER 17,2	005
		30. Name and address of person who	completed cause of death (Item 23a) (				
		ZATSILLE 31. Date filed (Month, Day, Year) NOV 2 3		111 PENN STREET	I BALTIMORE,	MARYLAND 2	1201

		1	For State Registrar	State	of Maryl		partment of F e <i>rtificate of I</i>			giene Reg. No.	005	37798
Ü			1. Decedent's Name (First, Middle, I	.ast)					2. Date of De Month	ath Day	Year	3. Time of Death
	Physicia		Audrey E. Griese						Nov. 1			8:10p M
	/Medic Examin	_	4a. Facility Name (If not institution, g		umber)		4b. City, Town, o	Location of Deat	h	4c. C	County of De	ath
	c c	Ÿ.	Charlestown Ret	rement	Center	2	Catonsv	ille		Ва	1timor	e:
	Funeral		5. Social Security Number 6	Sex	7. Age (In	yrs. last birthda	y) If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		th Year)	9. B	irthplace (State or Foreign Country)
	Director		213-10-2544	1 ☐ M 21公 F	8	36 Yrs.	World Days	Hours Will.	Aug. 21	1919		yland
	2		Usual Residence of Decedent									I and I having City I imite
	how I		10a. State 10b. County		100	. City, Town or	Location					10d. Inside City Limits 1 ☐ Yes 2 No
	and and and and and and and and and and	cto	MD Baltin	nore	(	Catonsv	ille					
	1 28 g	Director	10e. Street and Number				10f. Zip Code			10g. Citiz	en of What C	Country?
	within 72 hours after death with the Maryland ene. Than "natural", or itams 23a or 28a-f show Its Medical Examinar must be notified at	a	707 Maiden Choic	e Ln.			21228				USA	
	dea .	Funerai	11. Marital Status	12. Was De Armed F	cedent Ever forces?	in U.S. 13	<ol> <li>Was Decedent of H If Yes, specify Cuba</li> </ol>	ispanic Origin? (S in, Mexican, Puer	pecify Yes or No to Rican, etc.)	)- 1·	<ol> <li>Race - Am Black, Wh</li> </ol>	nerican Indian, nite, etc.
٥	or It		1 Never Married 2 Married		2CXNo		1 ☐ Yes 201 No		hite		Specify: W	hite
9500-91212	be filed within 72 hours after dea Ital Hygiene Id other than "natural", or Itams evant, Ille Medical Examinar m	d by	3 ∰Widowed 4 □ Divorced	Year or	Dates:							
ቪ	72 h	Completed	15. Decedent's (Specify only highest)	Education trade completed	1)	16a. Dec	cedent's Usual Occup ve kind of work done . DO NOT use retired	ation during most of wo	rking	16b. Kin	d of Busines	s/Industry
2	ithin Pan Pan	mμ	Elementary/Secondary (0-12)	College	(1-4or 5+)			")		D	anking	
N	filed v Hygie other t		12th 17. Father's Name (First, Middle, La	ct)		Tell	er	18 Mother's Na	me (First, Middle	1		
ב	be findal Personal Pe	Be	Fenby Cooper	31/					eisenda		,2,,,,,,,,	
3	should be ind Mental s marked o umatic eve	ဥ		(Time Driet)		10b 14a	illing Address (Street				Toum State	Zin Code)
Maryland	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		19a. Informant's Name/Relationship				50ems 1984			a .		
	1 and Health Am 27 ther to		Carolyn O'Dohe:	cty - da	ughte	r 120 b. Place of Dis	1 Poplar A	ve. Balt	imore, I	20c. Loc	and 21 ation - City o	r Town, State
altimore,	Pages nent of h int: If its iry or of		1 ☑ Burial 2 ☐ Cremation 3		m State	cemetery, c	rematory or other plac					
Ē	men tant: jury		* 4 □ Donation 5 □ Other (Spe		1		Park Cemet 22. Name and Addre	•				
Ba	permit. Pages Department of I Important: If its any injury or o		21. Signature of Funeral Service Lie	cho	m	01	3620 Wilk					
			23a. Party Enter the disease, or co shock, or heart failure. List or	emplications that	t caused the	death. Do not e						Approximate
			shock, or heart failure. List or Immediate Cause (Final		4.	4.1						Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)		tasta	ne L	ung Co	incer				
	Examiner			Due t	o (or as a cor	nsequence of):						
п		<u></u>	Sequentially list conditions,	b	o (or as a cor	nsequence of):						-
	ted	i i	Sequentially list conditions, if any, leading to immediate cause (Disease or injury									
_	xecu and al-tra	Examiner	that initiated events resulting in death) Last	c. Due t	o (or as a cor	nsequence of):						
58760,	ficate be executed physician and is the burial-transit	aiE										
387	phys phys s the	edicai		0								
×	death certifica a attending pl d for use as t	Ž	IF FEMALE: 23b. Was decedent pregnant		outcome of pr		_			2:	3d. Date of d	elivery
Вох	atter for u	Physician/M	in the past 12 months?		e birth 2 🗌 gnant at time		3 □Ectopic pregnancy 5 □ Other <i>(specify)</i> _	'			Month	Day Year
o.	the d y the ched	ıysi	1 □ Yes 2. No 9 □ Unknown	9□Unl	known							
Δ.	res that the de signed by the a be detached f	占	Part il. Other significant condition	s contributing to	death but no	t resulting in the	underlying cause giv	en in Part I.	23e. Did 1	obacco us	e contribute	to the cause of death?
ds	uires sign ld be	d by	Chronic Obs	truc ti	ve V	ulmon	ary Dis	ease.	10	Yes 2□	No 3 ₩	robably 4 Unknown
Ö	w require been si should t	iete					/		24a. Was	an	24b. Were a	autopsy findings available
He He	has ge 2	Completed		· · · · · · · · · · · · · · · · · · ·						ormed?	prior to death?	completion of cause of
a	n: The		27 141					00 Di 4 D-	1 Tes		1 ∐ Y€	es 2 No
Ĭ	iciar certii recto	Be	25. Was case referred to medical examiner?	Hospital:	7	2 ER/Outpat	Oth	00	ath (Check only and some state)		Doub (0-	
ō	Phys this raldi	<u>۲</u>	1 ☐ Yes 2 ☐ No 27, Manner of Death	11	☐ Inpatient te of Injury	28b. Time	ient 3 DOA	4   Nursing I	28d. Describe			өөспу)
S C	ding After fune	Ë	1 □ Natural 5 □ Pending	(Me	onth, Day Yea	ar) Injur	y Wo	k? Yes 2∐No				
<u>s</u>	deat deat ctor: y the	lica	3 Suicide 6 Could no	t be 28e, Pla	ce of Injury -	At home, farm,	street, factory, office		28f. Location (	Street and	Number or I	Rural Route Number,
Division of Vital Records,	lor A after Dira	Certification;	4  Homicide determine	bui	lding, etc. (S	pecify)			City or To	wn, State)		
	To the Hospitel or Attending Physicien: The law requires that the death certit within 24 hours after death.  To the Funeral Diractor: After this certificate has been signed by the attending to the Funeral Diractor: After this certificate has been signed by the attending completely illed in by the funeral director, page 2 should be detached for use a		29a. Certifier 1 Certifying	Physician: To t	the best of my	/ knowledge, de	eath occurred at the ti	ne, date and place	e, and due to the	cause(s)	and manner	as stated.
	ha Ho in 24 he Fu pletel	Medicai	(Check only 2 Medicel E. one)		anner stated.	mination and/or	investigation, in my o		urred at the time,			
	To To Eog	Z	29b. Signature and title of certifier	0	0		29c. Licens	e number		∠ya. Date	signea (Moi	nth, Day, Year)
			Deneen	Dow	Kin	(ma)	DY	4377		11/2	21/03	5
	$\wedge$		30. Name and address of person w	no completed ca	use of death	(Item 23a) (Typ	oe, Print)	, ,	1 ,			
	1		Deneen Bowlin	mo 7	-11 ma	riden (	Choice 1	-ane, C	stoner	lle,	MO	21228
	Sta		31. Date filed (Month, Day, Year)	2005	. Registrar's S		Sossie	•		,		
	Regist			*711111L	A STATE OF	1 24	F. SE SEPTEMBER					

State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 2. Date of Death Day 20 1. Decedent's Name (First, Middle, Last) GREEZICKI Year 1042 AM **Physician** 2005 FRANCES 4 November /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE JOHNS HOPKINS BAYVIEW MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Min 1 □ M **%** □ F Oct. 29,1950 Maryland Director 216-54-4536 Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits or 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Heath and Mental Hygiene.
ant: If item 27 is marked other then "natural", or Iteme 23e or 28e-f show ury or other treumatic event, the Medical Examinar must be calified at 1 ☐ Yes 2 🙀 No Dundalk Director Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21222 United States 2059 Larkhall Road Completed by Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2K Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Legal 7 Years Lawyer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elizabeth Thompson ၉ Hazel D. Murray 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Husband 2059 Larkhall Road Dundalk, Maryland 21222 Mr. Roger John Greezicki 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Hilltop Service Corp. 11/22/2005 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** SEPTIC SHOCK disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy 1 Live birth 2 Fetal death Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2 No P.0. the t detached 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed Division of Vital Records, þ CORONARY ARTERY 1 Tes 2 No 3 Probably 4 Unknown DISEASE Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? CARCINOMA METASTATIC 1 Yes 2 No 1 Yes 2X No e Hospital or Attending Physician: 24 hours after death. e Funeral Director: After this certifice 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 No ၉ the funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 🗌 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier RES 000 November Warine MD-PhD 20 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21287 BALTIMORE, MARYLAND 600 N. WOLFE STREET 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

		1 = For State Registrar	state of Maryla	nd / Depa	artment		n and M	,	9		270	nn
		Decedent's Name (First, Middle, Last)						2. Date of Dea	ath		3. Time of [	Death
Physi			James Vin	cent Ga	utier	i, Sr.		Month Novembe	er 20, 20	Year 005	12:00	$P^{M}$
/Med Exam		4a. Facility Name (If not institution, give stre				own, or Location	on of Death		4c. County o			
		12803 Claxton Drive	2		Lau	rel			Prince	e Geo	rge	
Funera	al	Social Security Number     6. Sex	20 =	s. last birthday)	If Under 1	Days Hour	der 24 Hrs.	8. Date of Birt (Month, Day	th v. Year)	9. Birthplac	ce (State or	Foreign
Directo	or	089-24-7440	<sup>2□ F</sup> 73	Yrs.	WIGHTIS	Day's Trool	1911111	Sept 2		New Y	ork	
pu *		Usual Residence of Decedent  10a. State 10b. County	10c (	City, Town or Lo	cation					104	d. Inside City	u Limito
laryta sho	5				Cation					100	ı. Iriside City 1 ∐Yes	
the N	ect	MD Prince Geo	orge L	aurel	10f. Zip (	2-4-			10- 011			
with	급								10g. Citizen of Wi	iat Country	7 f	
eath	Funeral Director	12803 Claxton Drive	Was Decedent Ever in	U.S. 13		708	Origin? (Spe	acify Yes or No-	U.S.A.	- American	Indian	
fter d	듄	1 Never Married 2 Married	Armed Forces? 1 X Yes 2 ☐ No				ican, Puèrto	ecify Yes or No- Rican, etc.)	Black	White, etc		
YIBING Z I Z I 3-UU30  uld be filed within 72 hours after death with the Maryland Mental Hygiene.  arked other than "natural", or Itams 23a or 28a-1 show atte event, I'm Medical Event in activational	þ	3 ☐ Widowed 4 🛣 Divorced	If Yes, Give Year or Dates: 1951	-66	1 ☐ Yes 2	X No Spec	city:		Specify:	White	<u> </u>	
72 ho	Completed	15. Decedent's Educat (Specify only highest grade of		16a. Dece	dent's Usual	Occupation	noot of worki	7.0	16b. Kind of Bus	iness/Indus	stry	
thin thin Week	ple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NDT use	k done during n e retired)	TOSE OF WORKI	ng				
A Vigien	5		4	Comp	uter p	program			Departme		f Defe	ense
yiand ould be file Mental Hy arked oth	Be	17. Father's Name (First, Middle, Last)				18. Mo	other's Name	(First, Middle,	Maiden Sumame	)		
Via ould Men arke	2	Antonioangelo N. Ga						Santeusa				
Mar nd 2 sh lth and lth and 27 ls m	0	19a. Informant's Name/Relationship (Type,							er, City or Town, S			
and and lealth m 27 har to		Joseph A. Gautieri	/son			N. Jones and Constitution of the Constitution	The second second	-	Maryland			
Or of H		20a. Method of Disposition 1 ☐ Burial 2 🖔 Cremation 3 ☐ Rem	oval from State	Place of Dispo cemetery, crei	natory or oth	e or ner place)		ate	20c. Location - C	ity or Town	i, State	
Fag. Fag. timen tant:		'4 □Donation 5 □Other (Specify)	W.					21, 05	Odenton	, Mar	yland	ι
DESIGNATION CE, MISTYISTIC Z.I.Z.I.S-UUSO permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked othar than "natural", or Itams 23s or 28a-1 show any injury or othar traumatic event, I'm Wedfeal Ever it is final to inclifted at	ODC	21. Signature of Funeral Service Licensee		D	onalds	Address of Fa	eral H	lome, P.	Α.			
40560	a	23a. Part 1. Enter the sease, or complicat	M00	113   3	13 Tal	Lbott A	ve. La	urel, M	Maryland		7 - 4 3 8 5 pproximate iterval Betw	
Examine  thysician and the burial-transit	al	Immediate C. use Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Metastatic Due to (or as a conse	equence of):	ic Can	icer					nset and De	eau
death certific	Physiclan/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	tal death 3	Ectopic pre				23d. Date Monti	,	ay Ye	ear
law requires that the as been signed by the 2 should be detached.	leted by F	Part II. Other significant conditions contrib	outing to death but not re	esulting in the u	nderlying car	use given in Pa	urt I.		obacco use contrib res 2 No 3			
e lay	Complet							24a. Was a autop perfor	sv Dri	or to compl ath?	y findings av letion of cau	vailable use of
VICION: The certificate rector, pag	Be C	25. Was case referred to medical				26. Pl	ace of Death	(Check only or				
ysic nis ce direc	70	examiner? 1 ☐ Yes 2 🔀 No	oital: 1 Inpatient 2	☐ ER/Outpatier	t 3 DOA	Other: 4	Nursing Hon	ne 5🛣 Resid	lence 6 Other	(Specity)		
Attanding Phy ar death.  Sector: After this by the funeral of	ertification:	27. Manner of Death 1 X Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	. 28 M	c. Injury at Work? 1 ☐ Yes 2	2		low injury occurred			
DIVIS cal or Atta s after de at Directo	Certific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, str cify)	eet, factory,	office	2	28f. Location (S City or Tow	Street and Number m, State)	or Rural R	oute Numbe	er,
To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.	edical (	29a. Certifier 1 ← Certifying Physici (Check only one) 2 ☐ Medical Examiner	an: To the best of my ki On the basis of examinand manner stated.	nowledge, death	occurred at vestigation, i	t the time, date n my opinion, d	and place, a death occurre	and due to the d ed at the time, d	cause(s) and manr date and place, an	er as state d due to the	e cause(s)	
To the To the Comp	Ž	29b. Signature and title of certifier			29c.	License numbe	өг	2	29d. Date signed (	Month, Day	y, Year)	
11		works				D52767			November	21,	2005	
161		30. Name and address of person who comp	leted cause of death (Ite	em 23a) (Type,	Print)					•		
17		Harminder Sethi,	M.D. 7350	Van Dus	sen Ro	ad, Lau	rel, M	Marylan	d 20707			
	State	31. Date filed (Month, Day, Year)	32. Regisfrar's Sign	nature								
Regis	strar	NOV 2 3 200	5 Alexan	B. A.	DENE	•						

			1 - For State Registrar	State of Ma		partment of leartificate of		nental Hygier Reg. Î	Z U U 5	37801
	Physici /Medic		Decedent's Name (First, Middle, La SOPHIE	st)	GC	RDON		2. Date of Death Month NOVEMBER	21 2005°	3. Time of Death 540 A M
ı	Examin		4a. Facility Name (If not institution, giv SINAI HOSPITAL	e street and number)			or Location of Death		4c. County of Death	N/A
	Funeral Director		5. Social Security Number 052-12-9303  Usual Residence of Decedent	Sex 7. Age	e (In yrs. last birthda 84 Yrs.	Months Days		8. Date of Birth (Month, Day Yea 08/20/192	ar) 9. Birthi	place (State or Foreign CANADA
	Maryland f show	tor	10a. State 10b. County  MD BALTIMOF	)F	10c. City, Town or OWINGS N					10d. Inside City Limits 1 ☐ Yes 2√ No
	a or 28a-	I Director	10e. Street and Number 8133 GREENSPRING			10f. Zip Code 21117			Citizen of What Cou	
0000	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene important: If item 27 is marked other than "naturel", or items 23a or 28a-f show important: If item 27 is marked other than "naturel", or items 23a or 28a-f show appropriately injury or other traumatic event, the Medical Exactivativativation once.	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1  Yes 2 X N If Yes, Give Year or Dates:	Ever in U.S. 13		Hispanic Origin? (Sp an, Mexican, Puerto Specify:		14. Race - Americ Black, White, Specify: WH]	etc.
U-01717	d within 72 ho giene. ir than "natur ir e Medical	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12) 12	ducation ade completed) College (1-4or 5	(Gin	edent's Usual Occu le kind of work done DO NOT use retire	pation during most of work d)	ring	. Kind of Business/In	dustry
Malia	ould be file Mental Hyg arked othe	To Be C	17. Father's Name (First, Middle, Last, MAYER	1	SCHACHT	ER	18. Mother's Nam	e (First, Middle, Maid	•	TUCKER
, Mar	and 2 sho ealth and in 27 is mu		19a. Informant's Name/Relationship (	Type, Print)	8133	GREENSPE	RING VALLE	al Route Number, City	NGS MILLS	, MD 21117
Saltimore	Pages 1 ment of H tant: If iten jury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Special		CARROLL	ematory or other pla	INC. 11/	23/2005 H		MD
Dall	permit. Page Department Important: If any injury o		21. Signature of Funeral Service Licel	atten	. 18	900 REIST	ERSTOWN R	LEVINSON OAD - PIK		
	Physician /Medical		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each lin	ie.	nter the mode of dyi	ng, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
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00/00	icate be executed physician and s the burial-transit	dical Exa	resulting in death) Last	Due to (or as a	a consequence of):		GERTIFICATION APPR	ROVED BY-MEDICAL EX	AMINER	
O. BOX 0	death certiff e attending id for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of 1 Live birth 1 4 Pregnant at 9 Unknown	2 Fetal death 3	□Ectopic pregnanc □ Other (specify) _	у		23d. Date of delive Month	ery Day Year
ras, r	The law requires that the ate has been signed by th page 2 should be detache	by	Part II. Other significant conditions of C 2 FRACTURE	ontributing to death bu	ut not resulting in the	underlying cause gr	ven in Part I.	23e. Did tobacco	o use contribute to the	ne cause of death? eably 4 Munknown
ai necor	The la ate has page 2	Completed						24a. Was an autopsy performed?	prior to co	psy findings available mpletion of cause of 2 No
OI VIII	Physician: this certificatal director,	To Be	25. Was case referred to medical examiner? 1 X Yes 2 □ No	Hospital: 1 ☐ Inpatier		ent 3 L DOA	ner: 4 Nursing Ho	th (Check only one)  me 5 \sum Residence	6 ☐Other (Specif	y)
SIOIS	To the Hospital or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	Certification:	27. Manner of Death  1 Natural 5 Pending  2 Accident investigatio  3 Suicide 6 Could not b	09/19/200	05 UNKA	Wo 1□	Yes 2 No	28d. Describe how in		
	iltal or Aturs after d rel Direct		4  Homicide determined	ASSISTED	ury - At home, farm, s : (Specify) LIVING FA	CILITY		OAL TIMODE	HEIGHTS A	VENUE
	ths Hosp hin 24 hou the Fune npletely fi	Medical	(Check only 2   Medical Exer	nysician: To the best on the basis of and manner sta	examination and/or	nvestigation, in my o	opinion, death occurr	red at the time, date a	(s) and manner as si and place, and due to	the cause(s)
	2	-	29b. Signature and title of certifier			29c. Licens	2376 7		Date signed (Month,	
	3		30. Name and address of person who	hemes.	D 243	W. Boke	pderes	Ve. Bat	to, Al z	1215
	Sta Registr	_	NOV 2 3 20		ar's Signature	met			,	

DHMH 17 Rev 1/2001

ORIGINAL

			1- State of Maryland / Dep	partment of Health and Nertificate of Death	Mental Hygie	2005	37802
<i>&gt;</i> *	Physici /Medio		Decedent's Name (First, Middle, Last)     Martin Edward Good	, Sr.	2. Date of Death Month	Day Year Der 20, 2005	3. Time of Death 6 a.m. M
*	Examir		4a. Facility Name (If not institution, give street and number)  10237 Baltimore National Pike  5. Social Security Number 6. Sex / 7. Age (In yrs. last birthda)		cott City	4c. County of Death	ward
	Funeral Director		219-28-7508 12 F 73 Yrs. Usual Residence of Decedent	Months Days Hours Min.	September 28	oar) Cour	place (State or Foreign ntry) Maryland
	ne Marylan 8a-f show ptiffied at	Director	10a. State 10b. County 10c. City, Town or I  Maryland Howard	Ellicott City		1	1 ☐ Yes 2 No
	ath with the 23a or 2		10e. Street and Number  10237 Baltimore National Pike	10f. Zip Code 21042		Citizen of What Cour	
036	hours after death with the Maryland turel', or Items 23s or 28s-1 show al Examinational be notified at	by Funerai	11. Marital Status  1 □ Never Married 2 Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 □ No tf Yes, Give 1951 Year or Dates: 1955	. Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify:	
21215-0036	within 72 ene. than nai	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	edent's Usual Occupation to kind of work done during most of work DO NOT use retired) Truck Driver	16b	b. Kind of Business/Inc	
Maryland	should be filed nd Mental Hygi marked other umatic event,	To Be C	17. Father's Name ( <i>First, Middle, Last)</i> Martin Elliott Good	18. Mother's Nam		Alice Funk	
	and 2 sealth ar m 27 is			ling Address (Street and Number or Rur 10237 Baltimore National F	Pike Ellicott City		042
altimore,	Page nent o ant: If ury or		1  Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)  Crest Lat	ematory or other place)	/23/2005	Marriottsville	
e C	permit. Departi Import any Inj.		23a. Part 1. Enter the disease, or complications that saysed the death. Do not en shock, or heart failure. List only one cause on each line.	Slack Funeral Home	Pike Ellicott Cit	ty, MD 21043	Approximate
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):	wc_			Interval Between Onset and Death
V 'na/a	certificate be executed adding physicien and use as the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):				
O. BOX 6	ding re as	Physician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	o <b>ry</b> Day Year
ecords, P.	requires that the death seen signed by the atter hould be detached for u	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	1	o use contribute to th	e cause of death?
nec	The la ate has page 2	Completed	Mul Fabrillation		24a. Was an autopsy performed?	prior to con death?	osy findings available inpletion of cause of
VII di	Physician: this certific ral director,	To Be	25 Was case referred to medical examiner? element of the saminer? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	Othor	me 5' Residence	6 Other (Specific	
JIVISION OF	ng Ph fter th		27. Manner of Death  ↑ Antural 5 ☐ Pending 2 ☐ Accident investigation  28a. Date of Injury (Month, Day Year) Injury		28d. Describe how in		,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)		28f. Location (Street City or Town, Sta	ate)	
	To the Hospital or within 24 hours afte for the Funeral Dir completely filled in	Medical	29a. Certifier (Check only one)  Check only one)  Check only one)  Check only one  Check one	th occurred at the time, date and place, ivestigation, in my opinion, death occurr	and due to the cause ed at the time, date a	(s) and manner as sta ind place, and due to	ated. the cause(s)
	To t To th	M	N. Joseph Gagliardi Man D	29c. License number		Date signed (Month, C	, ,
	5		30 Norma and nace acc at appropriate the second of the contraction of	125774 120 Kall Ney D1	2 Colin	by Mic	21045
	Sta Registra		31. Date filed (Month, Day, Year)  NOV 2 3 2005	park			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Vear Physician ncLind November 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Kandallstown Baltimore Dita If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Days Hours 1 X M 2 □ F Months 216-32-3117 Director Usual Residence of Decedent Manyland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Health and Mendal Hygeiner.

and of Health and Mendal Hygeiner and an artificial figure and a state of the and a state of the annual feet redifficial and ruy or other traumatic event, it a Medical Exercite ment feet redifficial and ruy or other traumatic event, it a Medical Exercite and an artificial and an artificial and an artificial and artificial and artificial and artificial and artificial and artificial and artificial and artificial and artificial and artificial and artificial artificial and artificial artificia ma. CARROLL 1 ☐ Yes 2 🖫 No Completed by Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.SA Idae Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No Specify: Specify: BLACK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 1274 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be LINdSEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MERITISVELLE, Md. 21104 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of h Important: If ita any injury or of once. 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State 11/22/05 \* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CHARLES 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ypoyly cemic o minutes /Medical Due to or as a consequence of): **Examiner** 19 Deves Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or): by Physician/Medical Examiner be executed and Due to (or as a consequence of): burial-t Box 68760. physician attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, tallure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown renu Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 1No Division of Vital o tha Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🖼 😽 o 2 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after deatl To tha Funaral Diractor: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier DZZZZZO death (Item 23a) (Type, Print)

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State Registrar 30. Name and address of person who completed cause of

MD

Mez

EILLS

31. Date filed (Month

1645

32. Registrat's Signature

	ا س	For State Registrar Amend ITEM  1. Decedent's Name (First, Middle, La	#19a P	er INF.	<b>G850</b> e	rtificat	905	Death		2. Date of De	Reg. No.		3 7 8 0 5
Physicia		Eleanor Hanral								Month	Day	Year	м
/Medic Examin		4a. Facility Name (If not institution, gir		mber)		4b. City	, Town, c	or Location of		<u>Novemb</u>		ounty of Dea	
		Suburban Hospi	tal				thes					ontgon	nery
uneral			Sex 1□M 2ਊF	7. Age (In yrs	. last birthday) Yrs.	If Unde Months	r 1 Year Days	If Under 24 Hours	Min.	8. Date of Bir (Month, Da	th y, Year)	, c	rthplace (State or Foreign ountry)
ector		087-12-1924 Usual Residence of Decedent	Λ	85	110.	]				May 28	, 1920	) New	York
=		10a. State 10b. County		10c. C	ity, Town or Lo	ocation						_	10d. Inside City Limits
iten of remarked unter their institutes, of remark of other traumatic event, the Medical Examiner must be notified at	cto	MD Montgon	ery		Rockvi	11e							1 □ Yes 2√∑ No
20		10e. Street and Number 6105 Montrose F	ond			10f. Zi	p Code	20	0852		10g. Citize	of What C	ountry?
	Funeral Director	11. Marital Status		edent Ever in t	J.S. 13.	Was Dece	ident of H			ify Yes or No	<sub>j</sub> 14.		erican Indian,
8		1 Never Married 2 Married	Armed Fo	24 No	1	_			Puerto R	ify Yes or No ican, etc.)	1	Black, Whi	
	qp	3 ☐ Widowed 4 🗓 Divorced	If Yes, Gi Year or D	Dates:		1 Yes	2 <b>X</b> 1 No	Specify:			St	pecify: W	nite
	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)		16a. Dece	dent's Usu kind of wo DO NOT o	ork done	during most of	of workin	gunk	16b. Kind	of Business	s/industry unk
	dmc	Elementary/Secondary (0-12)	College (	1-4or 5+)	1116.	DONOTE	130 / 01// 01	u)					
	Be C	17. Father's Name (First, Middle, Las				-		18. Mother	s Name	(First, Middle,	, Maiden Su	mame)	
	To B	Isidore Klass						Ro	ose ]	Oreier			
A COLOR		19a. Informant's Name/Relationship			19b. Maili	ng Addres	s (Street	and Number	or Rural	Route Numbe	er, City or T	own, State,	Zip Code)
		Kip Klass Hanrah Namey Hanrahan/da 20a. Method of Disposition	üghter	20b	11131 Place of Dispo			an Dri	ve R	eston,			r Town, State
DUCE.		1 ☐ Burial 2 ☐ Cremation 3 { 4 ☑ Donation 5 ☐ Other (Special			cemetery, crea	matory or	other pla	ce)			ZOC. LOCA	non - Ony o	Town, State
ei I		21. Signature of Funeral Service Lice Ronal I		7.	22	2. Name a	nd Addre	ss of Facility	1	CEE			Street
once		Ronald S.	Wage,	Directo	$\frac{\mathbf{r}}{\mathbf{B}}$	tate altim	Anat ore.	omy Bo MD 2	ard 1201	655 W.	Balt	imore	Street
		23a. Part Enter the disease, or con shock or heart failure. List only	plications that	caused the dea						respiratory a	rrest,		Approximate Interval Between
an		Immediate Cause (Final disease or condition	a	12	esa.	ive	for	y 9	-0	· /w	20		Onset and Death
cal ner		resulting in death)	Due lo	(or as a conse	quence of):								
	Į.	Sequentially list conditions, if any leading to immediate	b. Due to	(or as a conse	quence of):	m	in	14	,				
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		11	n a	an-	10	- h	-	677	Ca	· /ce	
	Exa	resulting in death) Last	Due to	(or as a conse	quence of:						\		
	dlcal	•	d										
	Med	IF FEMALE:	22- 14										
	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live !	itcome of pregr birth 2 □Fet nant at time of	al death 3	☐Ectopic p ☐ Other (s		у			230	I. Date of de Month	elivery Day Year
	ysic	1 Yes 2 No 9 Unknown	9□ Unkn		death 5	_ Cuiei (S	pecily) _		-				
	by PI	Part II. Other significant conditions	contributing to d	leath but not re	sulting in the u	nderlying	cause giv	ven in Part I.		23e. Did t	obacco use	contribute (	to the cause of death?
	ed t									10	Yes 2□t	10 3∏P	robably 4 Unknown
	Completed						_			24a. Was autor	an sv	24b. Were a	outopsy findings available completion of cause of
	Con									perto	med? 2 No	death? 1 ☐ Ye	s 2□No
1	Be	25. Was case referred to medical examiner?	Hospital:	/						(Check only o			
	2	1 Yes 2 No  27. Manner of Death	161		ER/Dutpatier 28b. Time o		DA			e 5 Resid			ecify)
כסווויים אין ווויסט ווו של נווס ועווסומן טווסטיטין, אמשם כי	tlon	1 Natural 5 Pending 2 Accident investigated		of Injury oth, Day Year)	Injury	м	28c. Injui Woi 1 🗆	rk? Yes 2 □ N		33. 203020	now injury o	CCUITOG	
	Certification:	3 Suicide 6 Could not l		e of Injury - At I	nome, farm, st	reet, factor	ry, office		21			lumber or F	Rural Route Number,
	Cert	4   Holfilde	build	ling, etc. (Spec	my)					City or Tox	wn, State)		
ı		29a. Certifier 1 Certifying P	miner: On the b	pasis of examin	owledge, deat ation and/or in	h occurred	d at the ti	me, date and	place, ar	nd due to the	cause(s) an	d manner a	is stated.
	Medical	one) 29b. Signature and title of certifier	and mar	nner stated.				se number					th, Day, Year)
		200. Organizate data tale of contine	2 6		0	0	)	-	p t				
		30. Name and address of person who	completed cau	se of death (Ite	m Zan (Type,	Print)	7 -	376	10		/-	16 -	2005
		William	B. 3	Dwa	nn	Tr		Ī	20	ckv	ille	, m	nd.
		31. Date filed (Month, Day, Year)	20. [	Registrar's Sign	atura	<del></del>							

ORIGINAL

		-	1 - For State Registrar	State of Ma	aryland		artment			and M	ental H	ygiene Reg. NZ	005	37806
			Decedent's Name (First, Middle, Last)		-					-	2. Date of D		0 0 0	3. Time of Death
	Physici		Elizabeth Jean Har	desty							NOV.	21,	2005	10:50 AM
1	/Medic Examin		4a. Facility Name (If not institution, give str	eet and number)			4b. City,	Town, or	Location o	f Death			county of Deat	h
			4201 Winding Way					tmin		0.4.1			arroll	
	Funeral		5. Social Security Number 6. Sex	7. Ag	e (In yrs. Ia 7.	st birthday) Yrs.	If Under Months	Days	If Under a	Min.	8. Date of B	19, Year	9. Birt 9. Birt 9. Ma	hplace (State or Foreign Fyland
ш,	Director	. }	Usual Residence of Decedent									157 15		
	inyian ihow		10a. State 10b. County			Town or Lo				y				10d. Inside City Limits
:	8a-f.s	octo	MD Carroll		We	stmin						10 0::		1 ☐ Yes 2 No
:	Mith ti	吉	10e. Street and Number 4201 Winding Way				10f. Zip					-	en of What Co ed Stat	
	ne 23	eral		. Was Decedent	Ever in U.S	S. 13. 1			spanic Orig	gin? (Spe	ocify Yes or N Rican, etc.)		4. Race - Ame	ncan Indian,
9	or Ite	풀	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give	No		lf Yes, spec 1 ☐ Yes 2		n, Mexican Specify:	, Puerto	Hican, etc.)		Black, Whit	
8	urel',	d b	3 Widowed 4 Divorced	Year or Dates:										nite
2	within 72 hours atter death with the Maryland ene. Than "naturel", or teme 23a or 28a-f show na M. Jical Examiner must be notillied at	Completed by Funeral Director	15. Decedent's Educa (Specify only highest grade	completed)		16a. Deced (Give	dent's Usua kind of wor DO NOT us	al Occupa rk done d se retired	ation <i>during</i> most I)	t of worki	ng	16b. Kin	d of Business	Industry
12	with iene. r then	E O	Elementary/Secondary (0-12)	College (1-4or 5	5+)		ol Bu					Pub	lic Scl	nool System
פַ	e filed al Hyg othe vent,	BeC	17. Father's Name (First, Middle, Last)								(First, Midd		Sumame)	
<u>ya</u>	ould b Ments arked aric e	2	George Skinner								g Wint			
Maryland 21215-0036	12 sh h and 7 is m traum	. 8	19a. Informant's Name/Relationship (Type		.7		ng Address Wind				Minste		Town, State, 2 2115	
(a)	1 and Healt tem 2	15	Robert Hardesty  20a. Method of Disposition	Husban		ace of Dispo					ate		ation - City or	
ē	Pages ent of nt: If II		1 ☐ Burial 2 🏿 Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State		metery, crei Carrol				11/22	2/05	Winf	ield,	MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Marylan Department of Health and Mental Hydiene.  Important: If team 27 is marked other than "naturel; or Iteme 29a or 28a-f show important: If team 27 is marked other than "naturel; or Iteme 20a or 28a-f show any njury or other traumatic event, the Machelle Examinat must be notified at answ night or other traumatic event, the Machelle Examinat must be notified at answ night.		21. Signature of Funeral Service Licensee									ome &	Cremato	ory, P.A.
<u> </u>	Dep Impo		Carl A. Lon										field,	MD 21784
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused cause on each li	the death ne.	. Do not ent	ter the mod	le of dyin	g, such as	cardiac o	r respiratory	arrest,		Approximate Interval Between Onset and Death
)	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Non	Sme		Mell	CLA	- m	الراب	-			Binus
	Examiner			Due to (or as		Merce on).	201	-a. \$1	7					3000
	- =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as			(003)		<u>~_</u>					
5	be executed icien and burial-transit	Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last	Due to (or as	2 22520211	once of								
,092	be executed sicien and burial-transit	cal E		Due to (or as	a consequ	erice or).								
687	# × #		d.											
Вох	h certi ending	M/V	23b. was decedent pregnant	c. If yes, outcome			∃Ectopic pr	rennancv				2:	3d. Date of de	
B	The law requires that the death certifica sie hes been signed by the attending ph sage 2 should be detached for use as th	Physician/Med	in the past 12 months? 1 Yes 2 No	4☐Pregnant a			Other (sp						Month	Day Year
<u>о</u> .	d by the	Phy	9 ☐ Unknown  Part II. Other significant conditions cont	phyting to death h	ut not resu	Iting in the u	inderhina c	ance and	en in Part I		23e Dio	d tohacco us	e contribute to	the cause of death?
ds,	ires that signed b	d by	COPO-1=100 las	AAL.	at not rosu	ining ar trio d	indonying o	auso givi	orran area	•		Yes 2□		robably 4 Unknown
Vital Records,	w requir been s should	Completed	200	VV 0Q							24a. Wa	as an	24b. Were a	utopsy findings available
æ	The lav	шо							-		au pe	topsy rformed?	prior to death? 1 ☐ Yes	completion of cause of
		0	25. Was case referred to medical						26. Place	of Death	1 ☐ Yes		10.103	2010
of <	Physicien: this certific ral director,	To B	examiner? 1 Yes 2 No	spital: 1  Inpatio		ER/Outpatie			4   140				Other (Spe	icify)
	ding P	<u></u>	27. Manner of Death  1	28a. Date of Inju (Month, Da		28b. Time o Injury	of 2	28c. Injun Work	yat k? Yes 2.∐		28d. Describ	e how injury	occurred	
Division	Il or Attending efter death. I Director: After d in by the fune	llcat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of In	jury - At ho	me, farm, st			.03 2		28f. Location	(Street and	Number or R	ural Route Number,
<u>≥</u>	al or setter	Certification:	4 Homicide	building, el	c. (Specify	)					City or 7	own, State)		
	To the Hospital or Attending Physicien: within 24 hours elter death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical C	29a. Certifier  (Check only  2 Medical Examin	cian: To the best	of my know	wledge, deat	th occurred	at the tin	ne, date an	nd place,	and due to the	e cause(s) a	and manner a	s stated.
	To the H within 24 To the F complete	Medi	one)  29b. Signature and title of certifier	and manner st	ated.				e number					th, Day, Year)
	5 th 0	-	zau. Signature and litte of certifier	3/1/			1			C.		1		
	1/-		30. Name and address of person, according to the contract of t	npleted cause	th (Item	23a) (Tvne	Print)	. , ,	,			, 50	N 500	W) 3.1147
	15		Alexander Pro	mland	201	iskin	2	hen	الحيد	ven	ما لي	المعالمة	-201.	westrute
	St Regist	ate	31. Date filed (Month, Day, Year)	32. Regist	rar's Signat	ture 🔾	and a			•			. (	

		•	State of Maryland / Department of Health and M  1- For State Registrar  Amend Item 23a, 27 per Dr., C549, 11, 23, U5dhb		
	Physicia /Medic	al	1. Decedent's Name (First, Middle, Last)  LOIS ELIZABETH HUTCHINS  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	2. Date of Death Month	Day Year 3. Time of Death  3.0 2005 // 20A M  4c. County of Death
	Examin Funeral Director	λ	St. Agnes Hospital Baltimore, 1  5. Social Security Number  6. Sex  1 M 2 XF  7. Age (In yrs. last birthday)  Whoths Days Hours Min.	8. Date of Birth (Month, Day, 2-2-19	N/A  9. Birthplace (State or Foreign Country)  32 SOUTH CAROLINA
	ne Maryland (8a-f show	Director	Usual Residence of Decedent	10	10d. Inside City Limits  1 ☑ Yes 2 ☐ No
99	72 hours after death with the Maryland Instural, or Nems 23s or 28s-( show Ocal Examiner mast be multicutal	Funeral	6762 REAL PRINCESS LANE  11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married  12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto  1 □ Yes 2 ☒ No It Yes, Specify:  1 □ Yes 2 ☒ No Specify:		USA  14. Race - American Indian, Black, White, etc.  Specify: BLACK
21215-0036	be filed within 72 hours after dea that Hygiene. I do that than "natural", or liems do out, the Modell Examinating	Completed by	3 X Widowed 4 □ Divorced Year or Dates:  15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  -12-  16a. Decedent's Usual Occupation (Give kind of work done during most of works)    If the complete of the complet	ing	6b. Kind of Business/Industry  SOCIAL SECURITY
Maryland 2121	2 should be file and Mental Hyg is marked oths aumatic event,	To Be C	17. Father's Name (First, Middle, Last) ERNEST C • JAMES  18. Mother's Name MARY F  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rura	RANCIS C	AMMON
	1 and Health Brn 27 thar tr		DONNA FLYTHE (DAUGHTER) 6762 REAL PRINCESS LN	. BALTIM	
Baltimore,	permit. Pages Department of I Important: if its any injury or o		4 □ Donation 5 □ Ott) or (Specify) CARRISON FOREST VETERANS  21. Signature of Funeral Service Licensee JONATHAN D. HIBNER Name and Address of Facility RED	D FUNERA	INGS MILLS, MARYLAND L SERVICE MORE, MARYLAND 21217
	Physician /Medical Examiner		23a. Part of the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of shock or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Aspiration Pneuro Due to (or as a consequence of):  Sequentially list conditions.		st, Approximate Interval Between Onset and Death
8760,	ate be executed hysician and the burial-transit	lical Examiner	Sequentially list conditions. If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that indiated events resulting in death) Last  Due to (or as a consequence of):  C. Due to (or as a consequence of):  J. J. Letton & PEG J. T.  d. Thetton & PEG J. T.		
P.O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	<b>Physicia</b> Wedi	IF FEMALE: 23c. Was decedent pregnant in the past 12 months? 1		23d. Date of delivery  Month Day Year
	w requires that been signed I should be det	ð	Part II. Office significant continuous continuous grounds and not receiving a rate and onlying cause grown a rate.	1 🗆 Ye	
tal Rec	ician: The law certificate has b rector, page 2 sl	e Completed		24a. Was ar autops perform 1 Yes 2	prior to completion of cause of death?  No 1 Yes 2 No
Division of Vital Records,	ding Phys	To B	examiner?  1   Yes   2   No		nce 6 Other (Specify)
Divis	Hospital or Attend 4 hours after death Funaral Director: tely filled in by the	I Certification:	3 Suicide 4 Homicide  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  29a. Certifier  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place,	City or Town	NIA
	To the Hospital within 24 hours a To the Funaral Completely filled	Medical	29c License number	red at the time, da	ate and place, and due to the cause(s)
	(0)		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Westong Mu, 900 Caton AVR, Baltimore Management of the field (Month Day, Year)  31. Date filed (Month Day, Year)	70	21229
1	1)	ate rar	31. Date filed (Month Day, Year) NOV 2 3 2005 NOV 2 3 2005 NOV 2 3 2005		~1~~

Lois Hutchins

			For State	State of Ma	ryland /			d Mental Hygie	ene	
	_		Registrar  1. Decedent's Name (First, Middle, La.	st)		Certificate of	or Death	2. Date of Death	No.	37808
	Physici		1200	Sie	E.	HILL		Month	Day Year	3. Time of Death
4	/Medic Examir		4a. Facility Name (If not institution, give	e street and number)		4b. City, Tow	n, or Location of De		4c. County of Death	6. 7-1
			3423 Edv	nondson	~ Av	e B	altim	ore	NIA	+
	Funeral		5. Social Security Number 6. S	ex 7. Age	(In yrs. last b	Months Da		in. 8. Date of Birth (Month, Day, Y	(ear) 9. Birth	place (State or Foreign
ь,	Director	4	Usual Residence of Decedent		21	Yrs.		Dec. 16,	1953 ma	anyland
1	yland now		10a. State 10b. County	,	10c. City, Tox	vn or Location			1.	10d. Inside City Limits
	a-f	ctor	ma.	VIA		Dalt	emor	e		1X Yes 2 □ No
4	or 28	Director	10e. Street and Number			10f. Zip Coo	ie : 2	10g	. Citizen of What Coul	ntry?
-	23a		3423 E	-amonds	on 1	tre	2122	9	OSA	<u> </u>
	Them Therr	Funerai	11. Marital Status 1 ☐ Never Married 2 Married	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☒ No		13. Was Decedent If Yes, specify (	of Hispanic Origin? Cuban, Mexican, Pu	(Specify Yes or No- terto Rican, etc.)	14. Race - Americ Black, White,	
5-0036	within /2 hours atter death with the Maryland ene. Then "neturel", or teme 23a or 28a-f ehow he Medical Exeminar must be nutitled at	<u>م</u>	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 □ Yes 20%	No Specify:		Specify:	3lack
2	netu Heat	Completed	15. Decedent's Ed (Specify only highest gra		168	. Decedent's Usual Oc (Give kind of work do	cupation	working 16	b. Kind of Business/In	dustry
2	hen in in in in in in in in in in in in in	mp	Elementary/Secondary (0-12)	College (1-4or 54	•)	life. DO NOT use re	wired)		Dones	lic
N :	Hygie Sther	ဝိ	17. Father's Name (First, Middle, Last)	10/4		11ouse		Name (First, Middle, Ma	iden Sumame)	
a	kad c	To Be	Adam Di	HILL			Ton	nie H-	emphi	_
Maryland	should and Men s marks tumatic	-	19a. Informant's Name/Relationship (	Type, Print)	19	b. Mailing Address (Str	eet and Number or	Rural Route Number, C	City or Town, State, Zip	Code)
	permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department if firm 27 is marked other then "neturelt, or flame 23a or 28a-f ehow any injury or other traumatic evant, the Medical Examinar must be notified at once.		Kenneth mo	re-Jo	n 3		rund for	~ Are: 13e	seto.md,	21229
ore.	rages 1 nent of Hi int: If fler iry or oth		20a. Method of Disposition  128 Burial 2 Cremation 3	Removal from State	20b. Place cemete	of Disposition (Name o	place) ///	Date 20	c. Location - City or To	own, State
	tment tant:		4 Donation 5 Other (Specif	y)	Irin	III CP	etery "/	26/05 F	sendal	K, md.
Ba	permit. Page Department i Important: If any Injury or		21. Signature of Funeral Service Licer	1500		1/2	270 Freatt	won Pass	. 2	1 = 0
	_		23a. Part1 Enjer the disease, or com	plications that caused	he death. Do	10 -0 - 11	mareh dving, such as card	funeral Horn		Approximate
	hysician		Immediate Cause (Final	one cause on each line	). M		, 3.			Interval Between Onset and Death
100	/Medical		disease or condition resulting in death)	a. LUNG (Due to (or as a	Consequence					Z I MONTHS
	Examiner		Sequentially list conditions	b						
ý	D #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequence	of):				
	cate be executed physicien and the burial-transit	xam	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a	consequence	of)-	•			
8760,	sicien buria		l	: 4						
	ilicate g physas the	edical		d						
ŏ	endin endin	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		n 3 Ectopic pregna			23d. Date of delive	эгу
. B	e deat he att	sicia	in the past 12 months? 1 Yes 2 No	4 Pregnant at t		5 ☐ Other (specify			Month	Day Year
Division of Vital Records, P.O. Box	Ine law requires thet the death certific site has been signed by the attending p paga 2 should be deteched for use as	Phy	9 Unknown					22. 5:4.4		
S,	signe signe signe	ρ	Part II. Other significant conditions of	ontributing to death bu	not resulting	in the underlying cause	given in Part I.		cco use contribute to the	he cause of death?
Š	w requir been si should	Completed								
Re	Ine lav	mp						24a. Was an autopsy performe	prior to co	ppsy findings available mpletion of cause of
ta	cartificate ractor, pag	0	25. Was case referred to medical				26 Place of F	1 ☐ Yes 2 No Death (Check only one)	No 1 □ Yes	28 No
>	ystc.	To B	examiner?	Hospital:	t 2 ER/O	utpatient 3 DOA	Othor	g Home 5 Residence	e 6 ∏Other (Specif	(v)
0	ng Ph fter th nerat		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day		Time of 28c. I	njury at Work?	28d. Describe how		77
Sio	fendin eath. lor; A tha fu	catio	2 Accident investigation 3 Suicide 6 Could not b			М	1 ☐ Yes 2 ☐ No			
Ν	or At offar d Direct in by	Certification:	4 Homicide determined	28e. Place of Injui building, etc.	y - At home, f <i>(Specify)</i>	arm, street, factory, off	ice	28f. Location (Stree City or Town, S	et and Number or Rura State)	il Route Number,
_	ours a ours a beral l		29a. Certifier Certifying Ph	vsician: To the hest of	my knowledo	e death accurred at the	a time, data and ale	ace, and due to the caus	-/->	
-	To the Hoepital or Attending Physicien: within 24 hours aftar death To the Funeral Director. After this cartifica completely filled in by the funeral director,	Medicai	(Check only 2 Medical Exar	niner: On the basis of	examination a	nd/or investigation, in n	ny opinion, death oc	ace, and due to the caus occurred at the time, date	and place, and due to	the cause(s)
	vithir To th comp	Me	29b. Signature and title of certifier				ense number	l l	. Date signed (Month,	Dey, Year)
)	,		· VIAI,				\$5506			0005
	Ń		30. Name and address of person who							
			UNIVERSITY OF MAR	KENNO GOEEN	SBAUM	CANGE CNI	E 223. (	defent St N	9E48 BALTIM	005, MD 21261
	Sta Registi		31. Date filed (Month, Pay, Year)	or segistral	s signature	Sparte				
DHM	IH 17 Rev 1/2		NOV 2 3 20	U) Jillieux	J.F.	March				

	1	For State Registrar	State of Maryland		artment of H			giene Reg. 2005	37809
Physicia /Medic	in,	1. Decedent's Name (First, Middle, Last)	neil HE	roi			2. Date of Dea Month	Day Ye	ar 4:35 PM
Examin	er	4a. Facility Name (If not instrution, give s BOATT METE KENA b SXTENDED CAPE (Second Security Number 6. Sex	reet and number)  Ilitation and  7. Age (In yrs. Ia	st hirthday	4b. City, Town, or Balti	MC C	e_	4c. County of E	Birthplace (State or Foreign
Funeral Director			M 2□F 86	Yrs.	Months Days		Aug. 17	y, Year)	Country) Outh Carolina
Maryland	ctor	10a. State 10b. County  Maryland N/A	10c. City	Town or Lo	ocation	Balti	more City		10d. Inside City Limits 1 Yes 2 □ No
with the	i Directo	10e. Street and Number 4815 East Hoffman	Street		10f. Zip Code	205		10g. Citizen of What United	
ING 21215-UU36  be filed within 72 hours after death with the Maryland tal Hygiene. d other than "naturel", or items 23a or 28e-f ehow event, the Medical Examinat must be notified at	by Funerai		2. Was Decedent Ever in U.S Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: WWII	5. 13.			? (Specify Yes or No- uerto Rican, etc.)		American Indian, Vhite, etc. White
27275-0036 ad within 72 hours af gjiana er than "naturel", or i he Medical Exert	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation	(Give	dent's Usual Occupa kind of work done of DO NOT use retired	during most of	working	16b. Kind of Busine	
€ 8 m 2 ≥	Be	8 Years 17. Father's Name (First, Middle, Last)	Unkn.	Hero	Painter	18. Mother's	Name (First, Middle, Annie Moi		9
ore, Maryland stand 2 should be file of Health and Mental Hy litem 27 is marked oth	욘	19a. Informant's Name/Relationship (Typ		19b. Mail	ng Address (Street		r Rural Route Numbe	er, City or Town, Sta	
C = 14 F		Sue A. VonStaden  20a. Method of Disposition	(Daughter)	ace of Disp	osition (Name of	1	Finksbur Date	g, Maryla:	
altimore, mit. Pages 1 a partment of Hea portant: if item y injury or othe		1 Burial 2X Cremation 3 R 4 Donation 5 Other (Specify)	amoval from State		matory or other place Service (	.	1/21/2005	Towson,	Maryland
Baltimol permit. Pages Department of important: if is eny injury or once.		21. Signature of Flur ral Service License	· Kully	I 7	922 Wise	Funera Ave.	l Home of Dundalk, N	Maryland	21222
law requires that the death certificate be executed  as been signed by the attending physicien and 2 should be detached for use as the burial-transit	licai Examiner	23a. Part. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, flary, Using to Immodiate Cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	Due to or as a consequ	ence of):	ter the mode of dyn	g, such as car	olde of Tesphatory an	100,	Approximate Interval Between Onset and Death
IS, P.O. BOX 68 ies that the death certifica igned by the attending pl be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	3c. If yes, outcome of pregnal 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3	□Ectopic pregnancy □ Other (specify) _	1		23d. Date of Month	f delivery Day Year
ds, P.O	ρ	Part II. Other significant conditions cor	stributing to death but not resu	ilting in the	underlying cause giv	en in Part I.			te to the cause of death?  Probably 4 Unknown
The The page	Completed					-	24a. Was autor perio 1 🗆 Yes	psy prior dea	e autopsy findings available r to completion of cause of th? Yes 2 \(\sum \) No
f Vital Reysicien: The Is certificate hadirector, page	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	lospital:	ER/Outpatie	ent 3 DOA Oth		Death (Check only only only only only only only only		Specify)
On O		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time Injury	of 28c. Injur		28d. Describe I	how injury occurred	
in the second	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, s	treet, factory, office		28f. Location ( City or Tox		or Rural Route Number,
Hospital 24 hours a Funerel I etely filled	edical		sician: To the best of my kno- ner: On the basis of examinal and manner stated.						
To the twithin 2. To the f	Me	29b. Signature and title of certifier			29c. Licens	se number		29d. Date signed (A	Month, Day, Year)
1 1 L	V	30. Name and address of person who co	empleted cause of death (Item	23a) (Type	056 (, Print) 3/14	SOS	WGS SHA	0	22,2005 -124f
51		3800 Lock Ra	ven B	lvol	B	altir	nore,	MOZ	124
Sta Regist		31. Date filed (Month, Day, Year) NOV 2, 3, 200	32 Registrar's Signa	iure	all!				

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			For State Registrar	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		tificate of		Reg. I	C) C) C) 500	37810
	Physici	an	1. Decedent's Name (First, Middle, Last)					Date of Death	Day Year	3. Time of Death
	/Medic	al	Dolly Harve	4		45 City Taylor	N	ovem be		205 452 PM
	Examin	er	4a. Facility Name (If not institution, give s  1. Social Security Number 6. Sex	togottal (	PIN (EV yrs. last birthday)	If Under 1 Year	r Location of Death	Vate of Birth	BOLH	more
п	Funeral Director			M 2×F 7	6 Yrs.	Months Days		Month, Day, Yes	929 VI	nplece (State or Foreign A
	pug *		Usual Residence of Decedent  10a. State 10b. County	10c	. City, Town or Lo	cation		/-/-		10d. Inside City Limits
	with the Maryland is or 28a-f show	P	MD NA	1.00.	Baltim					1 ☑ Yes 2 ☐ No
	r 28a-	Funeral Director	10e. Street and Number			10f. Zip Code		10g. (	Citizen of What Co	untry?
	23a o	aiD	6722 Brookmont	Orive		2	1207		U.S.A.	•
	tams 23	nuel		<ol><li>Was Decedent Ever i Armed Forces?</li></ol>	in U.S. 13. V	Vas Decedent of H Yes, specify Cuba	lispanic Origin? (Specify an, Mexican, Puerto Rica	Yes or No- n, etc.)	14. Race - Amer Black, White	
336	ours after death with the Manylar ral', or Itams 23a or 28a-f show Exarch or most be rediffed at	by F	1 Never Married 2 Married 3 X Widowed 4 Divorced	1 ☐ Yes 2 📉 No If Yes, Give Year or Dates:	1	☐ Yes 🏖 No	Specify:		Specify: B	lack
21215-0036	n 72 hours after "natural", or Ite colcal Exercit		15. Decedent's Educ (Specify only highest grade		16a. Deced	ent's Usual Occup	ation during most of working d)	16b.	Kind of Business/	
21	c * 0	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)						
	filed within I Hygiene. other than	CO	12th grade  17. Father's Name (First, Middle, Last)	na	Se	amstres	S 18. Mother's Name (Fin			form Co.
lan	Mental Mental arked o	To Be	James Jennings				Annie Cla		on demand,	
Maryland	should by and Menta is marked	-	19a. Informant's Name/Relationship (Typ	oe, Print)	19b. Mailin	g Address (Street	and Number or Rural Ro		y or Town, State, Z	ip Code)
	12 mg		Marjorie Jones-				Road, Bali			1207
Baltimore,			20a. Method of Disposition  1. Bunal 2 □ Cremation 3 □ Ri  4 □ Donation 5 □ Other (Specify)		b. Place of Dispos cemetery, crem	sition (Name of natory or other place	Date	20c.	Location - City or 1	Town, State
Itim	I. Perutant:		<ul> <li>4 □Donation 5 □ Other (Specify)</li> <li>21. Signature of Funeral Service License</li> </ul>		rownsv	Ille Vet	t. 11/28/C	5 Cro	wnsvill	e, Md
Ba	Depa Impo any i		Illyn B	Keke	Ma 43	rch F/H 00 Waba	West sh Ave, Ba		re, Md	21215
			23a. Paril. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.	Death. Do not ente	er the mode of dyin	g, such as cardiac or res	piratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a gor	CZTLIK	r vea	v+ rai	lave		•
Е	Examiner		Conversion to the secondary	allner	10 SCIE	volic	cardi	DIMIC	ulard	HECLE.
	D H	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a con	sequence of):	1 70.	20101010	1100		
	be executed icien and burial-transit	Examiner	that initiated events cresulting in death) Last	Due to (or as a con	Sequence of):	1 1141	Jev revi	2100		
760,		caiE								
89	certificate iding phys	•	0							
Вох	leath certificat attending phy I for use as the	an/N	230. Was decedent pregnant	3c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F		Ectopic pregnancy			23d. Date of delin	,
P.O. E	0 0 0	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ Ño 9 ☐ Unknown	4☐Pregnant at time 9☐ Unknown	of death 5 □	Other (specify)			Month	Day Year
	requires that the een signed by th hould be detache	y Ph	Part II. Other significant conditions con	tributing to death but not	resulting in the un	derlying cause give	en in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
Vital Records,	w requires that s been signed b should be deta	Completed by	- writhhe?	KIENO217				1 🗆 Yes	2 □ No 3 □ Pro	bably 4 Dunknown
ecc	> 12 10	npie	alzhelme	vs. den	nenth	7		24a. Was an autopsy	24b. Were aul	opsy findings available ompletion of cause of
al H	ticien: The lav certificate has rector, page 2:		hypo thui	oldism			1	performed? ☐ Yes 250		21 NO
	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner?	ospital:	2 ER/Outpatient	3 TOOA Oth	26. Place of Death (Ch			
10	g Phys er this ieral di	-	27. Manner of Death	28a. Date of Injury (Month, Day Yea		28c. Injun Worl	4 Nursing Home	Describe how in		iry)
io	Attending Freedath. sector: After by the funera	atio	1 Matural 5 Pending 2 Accident Investigation	(MOIIII, Day 18a	r) Injury		Yes 2 □No			
Division of	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Sp	At home, farm, stre ecify)	et, factory, office	28f. L	ocation (Street City or Town, Sta	and Number or Rui ite)	ral Route Number,
_	spital		29a. Certifier 12 Certifying Phys	ician: To the best of my	knowledge, death	occurred at the tim	ne, date and place, and d	ue to the cause	(s) and manner as	stated.
	the Ho nin 24 h the Fu npletely	Medical	(Check only one)	er: On the basis of exam and manner stated.	nination and/or inv	estigation, in my of	pinion, death occurred at	the time, date a	nd place, and due	to the cause(s)
	to To con	2	29b. Signature and title of certifier	wii Mun	clean	29c. License	e number	29d. C	Date signed (Month	Day, Year)
	1		30. Name and address of person who con	moleted cause of death	CHUMA STORE S	21) DC	1074761	N	o venine	V 14,200
	0		FRICH TOBIN M	Mayor Dim	1) 54	ol old	court ?	cad, l	2 amola	11stours
	Sta	- 1	31. Date filed (Month, Day, Year)	32 Registrar's Si	ignature				yland	- 1
· · · · · · ·	Registr	ar	NOV 2 3 2005	The same	A Spa	NE)		VV ICLV	Juna	21133

DHMH 17 Rev 1/2001

			1 - For State Registrer	State of M	laryland / Depa <i>Ce</i>	artment of H		,	giene	005	37811
	Physici		Decedent's Name (First, Middle, Last)     PHYLLIS		HIMMEL	STFIN		2. Date of Dea Month NOVEMBE	Day	2005	3. Time of Death 12:25 P M
}	/Medic Examin		4a. Facility Name (If not institution, give	street and number		4b. City, Town, or	r Location of D		4c. Co	unty of Death	
	Funeral		260 VISTA LANE 5. Social Security Number 6. Security Number	7. A	ge (In yrs. last birthday)	LUSBY  If Under 1 Year  Months Days	If Under 24 I	Hrs. 8. Date of Birt Min. (Month, Da)		9. Birth	place (State or Foreign intry)
	Director		Usual Residence of Decedent	X	75 Yrs.			05/15/1	930		NY
	Marylar I-f ehow	tor	10a. State 10b. County  MD CALVERT		10c. City, Town or Lo	ocation					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	with the	Director	10e. Street and Number			10f. Zip Code				of What Cou	intry?
	ems 23	Funeral	260 VISTA LANE	12. Was Decedent	t Ever in U.S. 13.	20657 Was Decedent of H If Yes, specify Cuba	ispanic Origin	? (Specify Yes or No- uerto Rican, etc.)		S.A. Race - Ameri Black, White	
036	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f ehow than "Asolesi Examiner nast be malified at	by	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Tyes 2 In If Yes, Give Year or Dates:	No	1 ☐ Yes 2 No	Specify:	55115   115411, 5151,			ITE
21215-0036	be filed within 72 hours ital Hygiene. d other than "natural", event, the Mcdical Exa	Completed	15. Decedent's Edu (Specify only highest grad	completed)	(Give	dent's Usual Occup kind of work done of DO NOT use retired	during most of	working	16b. Kind	of Business/Ir	ndustry
	e filed with It Hygiene. other the vent, the		Elementary/Secondary (0-12)  17. Father's Name (First, Middle, Last)	College (1-4or 5+	TEAC	CHER	40 Mathada	Name (First Middle		CATION	
Maryland		To Be	SAMUEL		HIM	MELSTEIN	BESS	Name <i>(First, Middl</i> e, SIE	Maiger 3u		REPOLSKY
Mar	12 sh h and 7 Is m traum		19a. Informant's Name/Relationship (Ty ELLIOTT MILLER /	pe, Print) COUSIN		•		r Rural Route Numbe	,		
ore,	- I = E		20a. Method of Disposition 1 ★ Burial 2 ☐ Cremation 3 ☐ F		20b. Place of Dispo			Date		tion - City or T	
Baltimore,	그 든 원 등 .		* 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licens	99 0 111	BETH ISRA	AFI_ 2. Name and Addre	ss of Facility	/22/2005		1.5	
ä	Dermi Depa Impo eny ii		23a. Part1. Enter the disease, or compl	Cittle Cause	ed the death. Do not en	900 REIST	ERSTOWN	SOL LEVINS   ROAD - P	<b>IKESV</b>		INC. MD 21208 Approximate
1	Pnysician		shock, or heart failure. List only of Immediate Cause (Final disease or condition	ne cause on each	ta ctabi			ncer	1631,		Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or a	s a consequence of):	010		.,,,,,			10
D	ed sit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	s a consequence of):						
,	cate be executed bhysician and the burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or a	s a consequence of):						
68760	ifficate b g physic as the b	ledical		1							
Вох	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/M	in the past 12 months?		2 Fetal death 3	□Ectopic pregnancy □ Other (specify)	1		230	I. Date of deliv	very Day Year
P.O.	d by the	Physi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown  Part II. Other significant conditions co	9☐ Unknown			on in Deet 1	220 Did t	hanna usa	contribute to	the cause of death?
rds,	w requires that been signed I should be det	ed by	Tarris of agricultural conditions of	Thibdiang to death	Dut not resulting at the t	anderlying cause giv	en in Faiti.				bably 4 Unknown
Records,	The law re cate has be- page 2 sho	Completed						24a. Was autop perfo		24b. Were aut prior to co death?	opsy findings available ompletion of cause of
Vital	ysician: Th is certificate director, pag	Be Co	25. Was case referred to medical examiner?					1 ☐ Yes  Death (Check only of	2 ZNo	1 🗆 Yes	2 No
of	Phys this ral dii	2	1 ☐ Yes 2 No 27. Manner of Death	1 Inpat 28a. Date of In (Month, D				ng Home 5 × Resid		Other (Speci ccurred	(fy)
Division	r Attending er death. rector: Atter by the fune	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be		njury - At home, farm, si	M 1 🗆	Yes 2 □ No	28f. Location (	Street and N	lumber or Ru	ral Route Number,
Ωį	ital or A irs after rel Directed in by		4 Homicide determined	building, e	etc. (Specify)			City or Tov	m, State)		
	To the Hospital or Attend within 24 hours after death To the Funerel Director: completely filled in by the	Medical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	ner: On the basis and manner s		rvestigation, in my o	pinion, death o	occurred at the time,	ause(s) an date and pla	d manner as a ace, and due	stated. to the cause(s)
<b>.</b>	To the within 2 To the complet	×	29b. Signature and title of certifier	Pet	1	29c. Licens	e number	- /		signed (Month)	Day, Year) 2005
	,0 By		30. Name and address of person who c	ompleted cause of	death (Item 23a) (Type	. Print)	66	m A			2000
	St	ate	31. Date filed (Month, Day, Year)	† <i>e</i>   32. Regis	strar's Signature	C43	DDY,	114.			
	Regist	rar	NOV 2 3 2005	J. Billian	and the same						

		•	For State Registrar		Maryland /		rtmen tificate			d Mental H	Reg. No.	2005	37812
	ysicia		Decedent's Name (First, Middle, Last     MARGARET	Δ			KF	241	IER	2. Date of D Month	Day		3. Time of Death 2 ( 15 M
	Medic amine		4a. Facility Name (If not institution, give				-		Location of De	eath		. County of Deat	h
Fun	oral		Johns Horkins 5. Social Security Number 6. S	BAYVIG	Age (In yrs. last t	oirthday)	If Under	1 Year	ore C		irth	n / a	a hplace (State or Foreign
Dire		1	213-32-3133	□M 2 <b>/3</b> F	70	Yrs.	Months	Days	Hours N	lin. 8. Date of B (Month, 2)	3 / 35	Ma	ryland
/land	Hi .		Usual Residence of Decedent  10a. State 10b. County	-	10c. City, To	wn or Lo	cation	_	<del>.</del>				10d. In side City Limits
72 hours after death with the Maryland natural; or Items 23e or 28e-f show	peilified	Director	Md n,	a		Bal	timo	re					1 X Yes 2 □ No
with the	I Be no	Dire	10e. Street and Number 427 Elrino Str	oot			10f. Zip	212	22/1		10g. Cit	izen of What Co USA	ountry?
Jean	ET III	Funeral	11. Marîtal Status	12. Was Decede		13. \	Vas Deced			(Specify Yes or Nerto Rican, etc.)	lo-	14. Race - Ame	
jiene. r than "natural", or Items 23e or 28e-f show	Examine	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	1   Yes 2 If Yes, Give Year or Date	No		Yes 2		Specify:	eno rican, etc.)		Specify: W	nite
"natu	edical	lete	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16	(Give	lent's Usua kind of wor DO NOT us	k done a	lurina most of	working		ind of Business/	·
giene.	The M	Completed	Elementary/Secondary (0-12)	College (1-4	or 5+)		ashi				Joh	nns Hop Hospi	okins tal
be filled ital Hygi ed other	avan	Be	17. Father's Name (First, Middle, Last)	T-1						Name (First, Middl		Sumame)	
should by or or or or or or or or or or or or or	matic	၉	Joseph Henry  19a. Informant's Name/Relationship (		15	b. Mailin	a Address	(Street a		aine Ma			Zip Code)
and 2 salth ar	othar treumatic		Mr. Ramon R. Fa	•							-		A. 22407
90=	5		20a. Method of Disposition 1 ☐ Burial 2 爲Cremation 3 ☐		118	tery, cren	natory or of	ther place		Date		ocation - City or	
art ar	injury P.	ľ	<ul> <li>4 □ Donation 5 □ Other (Specify</li> <li>21. Signature of Funeral Service Licer</li> </ul>							/21/05 neral H			e, Md.
Dep d	any ir		Eugene).	Cutto	h								1. 21222
Physic /Med			23a. Part1. Enter the disease or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a Second a	and Third	de				diac or respiratory		of body	Approximate Interval Between Onset and Death
Exami			Conventinity list conditions	Inhal	as a consequence	e of):	UN					/	6 hours
cuted	ransit	Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or	as a consequence	e of):	7 ,			1//	1/	EXAMINER	
ate be exe hysician a	he bur	ical	resulting in death) Last	Due to (or	as a consequence	e of):				Me K	WEDICAL		
ath certif	or use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No		2 Fetal dea t at time of death		Ectopic pro		CERTI	ICATION IN		23d. Date of deli Month	ivery Day Year
that the de ed by the a	Jetach	Phys	9 ☐ Unknown  Part II. Other significant conditions of			in the u	darhina o	NICO GIVE	o in Part I	23a Did	tobacco i	use contribute to	the cause of death?
een signe	Pe	ted by	Takin one significant continuous			) III (IIO UI	idenying ca	use give	THE CALL.		Yes 2		obably 4 Unknown
	page 2	Completed					<del></del>				s an opsy formed? 2 XNo	24b. Were au prior to death?	topsy findings available completion of cause of 2 No
certifi	rector	o Be	25. Was case referred to medical examiner?  1 Yes 2 □ No	Hospital: 1 Inp	-*i* 0		• • • • • • • • • • • • • • • • • • • •	Othe	P*	Death (Check only	-	o = 0 = 40	W. 1
Affe	uneral	-	27. Manner of Death  1 Natural 5 Pending  2 Accident investigation	28a. Date of (Month,	njury 28b Day Year)	Time of Injury	28	Bc. Injury Work		g Home 5 Res	how injur		
5 # E	d in by the	ertification:	3 Suicide 6 Could not be determined	28e. Place of building	Injury - At home, etc. (Specify)	_		, office			own, State	- SALTIN	ral Route Number,
within 24 hours a	completely filled in	edical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medicel Exer	and the second of		ge, death and/or inv	occurred a restigation,	at the tim in my op	e, date and pla inion, death o	ace, and due to the courred at the time	cause(s) , date and		
within 2 To the	comp	Me	29b. Signature and tith of certifier	0	1. I N	L -	29c	. License	number		29d. Dat	te signed (Month	n, Day, Year)
			* To	Med	fical Lb	CTOR	R	es-	000		Noven	nber 19	2005
f			30. Name and address of person who Christ-ober Frec	completed cause	Hookine	(Type,	Print)	940	Factor	Avenie	Dal:	timose	21774
	Sta		31. Date filed (Month, Day, Year) NOV 2 3 200	Reg	istrar's Signature	Soa	رانگ	110	701	Avenue	, it the	1,500	

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	1 - For State Registrar	State of Ma	arylan	•	artmen tificate			Mental Hy	giene	0.0	)5	37813
	Physici /Medic	al	1. Decedent's Name (First, Middle, Last)	. K	M					2. Date of D Month	Day	1	O5	3. Time of Death
	Examin Funeral	er	4a. Facility Name (If not institution, give s Harford Memorial  5. Social Security Number 6. Sex	Hospital 7. Ag	e (In yrs.	last birthday)	Hav If Under	re D	Location of Dea C Grace If Under 24 Hr	s. 8. Date of B	H irth	arfo	9. Birtho	lace (State or Foreign
	Director		220-06-7071 1	]M 2 <b>X</b> F	87	Yrs.	Months	Days	Hours Min	AUG • 2		918	Cour	Korea  Od. Inside City Limits
	th the Marylan or 28a-f show e notified at	irector	MD Anne Arun  10e. Street and Number	idel 	Seve		10f. Zip	Code			10g. Cit	izen of V	What Cour	1 ☐ Yes 2 No
9003	within 72 hours after death with the Maryland ene. than "natural", or itama 23a or 28a-f show than "Ancile Exe. ither rest be rediffed at	d by Funeral Director	1 ☐ Never Married 2X Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:			I□Yes 2	lent of His ify Cubar ☑XNo	Specify:	(Specify Yes or Nerto Rican, etc.)		Blac Specify	e - Americ ck, White, : Asi	etc. .an
21215-0036		Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		i+)	16a. Deced (Give life. L Homem	kind of wor DO NOT us	k done di	uring most of w	rorking			Home	dustry
Maryland	should be filed ind Mental Hygis marked other umatic evant, II	To Be (	17. Father's Name (First, Middle, Last) Unknown						Un	ame (First, Middle known				
	1 and 2 s Health ar am 27 is ther trau		19a. Informant's Name/Relationship (Ty),  Kyong Lee – daught  20a. Method of Disposition		20b. F		Clear	wate	r Court	Rural Route Numb	, MD	21	State, Zip	
Baltimore,	permit. Pages Department of Important: If It any injury or o		1X Burial 2 Cremation 3 R '4 Donation 5 Other (Specify)  21. Signature of Pineral Service License			ndowrid Ga	ge Me Name an ry L.	m. P d Address Kau	ark 11/ s of Facility fman Fu	22/2005 neral Ho	El me @ 1	krić Meac	lge, l lowri	
	death certificate be executed  Water and many many many for use as the burial-transit deforuse as the burial-transit many many many many many many many many	dical Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ne cause on each li	a conseq a conseq	h. Do not entous twe uence of):	er the mode							Approximate Interval Between Onset and Death 2 days.
O. Box 6	that the death certific ed by the attending p detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	3c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Feta	Ideath 3□	Ectopic pre				2	23d. Dat Moi	e of delive	ry Day Year
rds, P	sign d be	þý	Part II. Other significant conditions con	ntributing to death b	ut not res	ulting in the ur	nderlying ca	ause give	n in Part I.			se contr	ribute to th	e cause of death? ably 4 Unknown
al Record		Completed								24a. Was auto perfe		0	Were autoportion to confleath?	osy findings available inpletion of cause of
Vital	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	fospital: 🌙.				Otho		eath (Check only				
of	Phys rthis ral di	tion; To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date o Inju (Month, Da	rv I	ER/Outpatien 28b. Time of Injury		Bc. Injury Work	at Nulsing	Home 5 Res				")
Division	To the Hospital or Attanding within 24 hours after death.  To tha Funaral Diractor: Afte completely filled in by the fune	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injuding, etc.	ury - At ho c. (Specify	ome, farm, stre	eet, factory	, office		28f. Location ( City or To			er or Rura	Route Number,
	To the Hospital within 24 hours a To the Funeral completely filled	Medical	29a. Certifier (Chack only one) 1 Certifying Phys 2 Medical Examination	ner: On the basis of	examina	tion and/or inv	estigation.	in my opi	nion, death occ	curred at the time,	date and	place, a	and due to	the cause(s)
	To T com	Σ	29b. Signalure and title of certifier	mo	)		29c.	License D3	2609	de Gran	29d. Dat	e signed	(Month, I	Day, Year)
	X		30. Name and address of personatio co	mpleted cause of d	eath (Item	evolut	Print)	; <del>+</del> -+	Carre L	de Grac	1 M	021	678	
	Sta Registr	-	31. Date filed (Month, Day, Year)	32 Registra	ar's Signa	iture	well							

		1 - For State Registrar		ryland / De	partment of H ertificate of L	ealth and M	lental Hyg	_		37811
Physic /Med	ical	1. Decedent's Name (First, Middle, Last)			KIN		2. Date of Deat Month Novembe	Day Y	9er 2005	Time of Death
Exam Funera Director		4a. Fecility Name (If not institution, give s    Social Security Number   6. Sex   212-42-4771	CACE CE	NTER (In yrs. last birthda 83 Yrs	BALT IN C	Location of Death  C.F.  If Under 24 Hrs.  Hours Min.	8. Date of Birth	4c. County of BALTIME  1922	25 C	(State or Foreign
D		Usuel Residence of Decedent  10a. State 10b. County MD Baltimo	ore	10c. City, Town or Catonsv					10d. lr	nside City Limits
h with the 23a or 28s	ai Director	10e. Street and Number 5 Reacher CT.			10f. Zip Code	228	1	0g. Citizen of Wh		
USO ours after deat al', or Items ? Eraminer mu	by Funerai	11. Marital Status  1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 N If Yes, Give Year or Dates:		3. Was Decedent of His If Yes, specify Cubar 1 Yes 2 No	spanic Origin? (Spin, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		American In White, etc. White	
ING XIXISOUSS  be filed within 72 hours after death with the Marylan hall Hygiene.  dother than "natural, or tiems 23a or 28a-f ehow  event, the Medical Examinat must be notified at	Completed	15. Decedent's Educ (Specify only highest grade Elementary(Secondary (0-12)	cation completed) College (1-4or 5	(G.	cedent's Usual Occupa ive kind of work done d a. DO NOT use retired) emaker	uring most of work	ing	16b. Kind of Busin		,
Maryland  2 should be filed th and Mental Hyg 7 is marked othe traumatic event,	To Be C	17. Father's Name (First, Middle, Last) William George Si	nith			18. Mother's Name Cather	e (First, Middle, A			
IOre, Maryis ges 1 and 2 should t of Health and Mer if tem 27 is marke or other traumatic		19a. Informant's Name/Relationship (Ty) Bernardine Orefice		r 5 R	ailing Address (Street a Leacher Ct.	Catonsvi	ille, Ma	ryland 2	1228	
Daltimore permit. Pages 1 Department of H Important: if Itel any injury or ott		20a. Method of Disposition  1 Burial 2 Cremation 3 R  4 Donation 5 Other (Specify)		cemetery, c	sposition (Name of trematory or other place bly Redeeme	r 11/2	23/05	20c. Location - Cit Baltimor	e, Mar	yland
Departition once.		21. Signature of Furneral Service License	2		22. Name and Address 6415 Belai	r Road Ba	altimore	, Maryla	nd 212	206
Physician /Medical Examiner		shock, or heart allure. List only on Immediate Caus. Final disease or condition resulting in death)	Due to (or as a	e.  PACTU  a consequence of):	enter the mode of dying	g, such as cardiac (	or respiratory arre	est,	Inter	roximate val Between et and Death
be executed ician and burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, cuis-ass or injury that initiated events resulting in death) Last	Due to (or as a	POCOSIS a consequence of):						
the death certificate y the attending physiched for use as the	hysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death	3 □Ectopic pregnancy 5 □ Other (specity)			23d. Date of Month	f delivery Day	Year
Ords, F.O. BG requires that the death een signed by the atter hould be detached for u	by P	Part II. Other significant conditions con  CORUNA RY AR		it not resulting in the	, ,	n in Part I.		acco use contribu		
The lay ate has page 2	Completed	DEMENTIA					24a. Was ar autops perform 1 Yes 2	y prio	r to complete	ndings available on of cause of
Or VItal Physician: 1 rithis certifical ral director, pr	o Be	25. Was case referred to medical examiner?	ospital:	nt 2 ER/Outpat	ient 3 DOA Othe	26. Place of Death			(Specify)	
JIVISION OI I or Attending Physafter death. Director: After this I in by the funeral di	ertification: T	27. Manner of Death  1 Actural 5 Pending investigation	28a. Date of Injur (Month, Day	y 28b. Time	of 28c. Injury Work		28d. Describe ho		<i>ороспу</i> /	
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	O	3 Suicide 6 Could not be 4 Homicide determined	building, etc	(Specify)	street, factory, office		City or Town	,		e Number,
the Hosp in 24 hou the Fune	Medical	one)	sician: To the best of ner: On the basis of and manner sta	examination and/or	eath occurred at the time investigation, in my op	inion, death occurr	ed at the time, da	ite and place, and	due to the c	
το Το σπ	2	29b. Signature and title of certifier			29c. License			d. Date signed (A		2005
10		30. Name and address of person who co			e, Print)	63164		IMORE, I		
Ψ 	tatė	31. Date filed (Month, Day, Year) NOV 2 3 2005	32. Registra	05 HcPc	NS BAYVIE	w circu	E BALT	IMORE, I	10 =	21224
Regis		NOV 2 3 2005	Ella sea	St Age	345					

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NOV 2 3 ZUUD

		For State of Maryland / D	epartment of Health and N Certificate of Death	lental Hygie Reg.		37816
表 著		Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
Physicia /Medic		Sylvia Lantz		Novembe.	$\overset{Day}{r} 12 \overset{Year}{200}$	5 1920 M
Examin	_	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
		Anne Arundel Medical Center	Annapolis		Anne Ar	undel
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birt 1 ☐ M 2 ☐ M 2 ☐ M 5 ☐ M	Months Dave House Min	8. Date of Birth (Month, Day, Ye June 2.2	ear Cou	place (State or Foreign intry) ginia
puq s		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town	or Location			10d. fnside City Limits
Aarylan f show	0	Taryland Anne Arundel Crof				1 ☐ Yes 2 <b>X</b> ☐X\0
the A	ect	10e. Street and Number	10f. Zip Code	10g.	. Citizen of What Cou	intry?
ath with the Maryla 23a or 28a-f shou ust be nutified at	Funeral Directo	2914 Middlebridge Ct.	21114		USA	
er death	Dera	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Sp	ecify Yes or No-	14. Race - Amer	
1 a a	by Fu	1 Never Married  Married  1 Yes, Give   3 Widowed 4 Divorced  Year or Dates:	ff Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes ※ No Specify:	nican, etc.)	Black, White	lack
72 hours "natural",	Completed	15. Decedent's Education 16a. (Specify only highest grade completed)	Decedent's Usual Occupation     (Give kind of work done during most of work	161	b. Kind of Business/le	ndustry
be filed within 72 ho hal Hygiene. Id other than "natur event, the Madical	nple	Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT use retired)			
ed wi ygien rer th	S	12th lyr F	olice Officer		ashingto	n D.C.
be fill d oth	Be	17. Father's Name (First, Middle, Last) Charles Lejune		e (First, Middle, Mai	den Sumame)	
should nd Men marke maric	ဥ		Mailing Address (Street and Number or Run	Harvey	its as Town State 7	in Control
d 2 sl th and th and th and traur			14 Middlebridge C		-	
is 1 and 2 should be filed within the what had when a Hygiene. It marked other than other traumatic event. The Market was the world the way to be a should be a sh		20a Method of Disposition 20b. Place of	Disposition (Name of		c. Location - City or T	
permit. Pages 1 Department of H Important: If ite any injury or ot		'4 □Donation 5 □ Other (Specify) Harmo		9-05 H	yattsvi1	1e, Md.
Deparitmbor any ir		21. Signature of Funeral Service Licensee  Lavy 11, Reese Moo483	22. Name and Address of Facility Wm. Reese & Sons 821 West St. Ann	Mortua:	ry, P.A. Md. 214	01
X.		23a. Part1. Enter the disease, or complications that caused the death. Do n shock, or heart failure. List only one cause on each line.				Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	10 MAMERTAN			Onset and Death
/Medical Examiner		resulting in death)  Due to (or as a consequence of	rf):			
	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	of):			
cuted	Examiner	cause. Enter underlying Cause (Disease or injury that initiated events  c				
cate be executed physician and the burial-transit		resulting in death) Last Due to (or as a consequence of	f);			
sate b	dicai	d				
ding p	•	fF FEMALE: 23c. If yes, outcome of pregnancy			221 221 (115	
w requires that the death certify been signed by the attending ishould be detached for use as	Physician/M	in the past 12 months?  1 ☐ Live birth 2 ☐ Fetal death	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of deliv Month	Day Year
the d	ysi	1 Yes 2 No 9 Unknown 9 Unknown				
s that	by Pt	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobac	co use contribute to	the cause of death?
aquire en sig				1 ☐ Yes	2 □ No 3 □ Pro	babfy 4 Unknown
2 8 8	Completed			24a. Was an autopsy performed	prior to co	opsy findings available ompletion of cause of
ician: Th	ပို	25. Was case referred to medicaf	26 Place of Death	1 Yes 2 2	YNo 1 ☐ Yes	2 No
ysicie ysicie	0 8	examiner? 1 Yes 2 No  Hospital: 1 Inpatient 2 EP/Out	Other		e 6 □Other (Speci	(v)
ding Phy After thi funeral	n: T	27. Manney of Death  28a. Date of Injury (Month, Day Year)  If		28d. Describe how i		
endir sath. or: Af	atic	2 Accident investigation	M 1 Yes 2 No			
To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: Atter this certificate his completely filled in by the funeral director, page	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of fnjury - At home, far building, etc. (Specify)	m, street, factory, office	28f. Location (Stree City or Town, S	t and Number or Rur State)	al Route Number,
spital	aj C	29a. Certifier 1 Certifying Physician: To the best of my knowledge	, death occurred at the time, date and place.	and due to the caus	e(s) and manner as	stated.
he Hoo n 24 h he Fur bletely	edical	(Check only one)  2 Medical Examiner: On the basis of examination and and manner stated.	Vor investigation, in my opinion, death occurr	ed at the time, date	and place, and due t	to the cause(s)
To ti withii To ti comp	ž	29b. Signature and title excertifier	29c. License number	29d.	Date signed (Month,	Day, Year)
/		A MANNA IND	620770		11/15/2	410
		30. Name and address of person who completed cause of death (Item.23a) (	Type, Print) ASY) AVG	Anno	poly, Ar	10
Sta		31. Date filed (Month, Day, Year)  32. Registrar's Signature	Acade 1			
Registr	ar	NOV 2 3 2005	provide a second			

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Amend items 8, 11 per fb 9849 11-23-05 VI

Physicia	G .	6 6 - 6 - 6 - 6	Reg. 2. Date of Death Month	No. 0 0 5	3. Mime of Death
/Medic	al	a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	VOVEMB	4c. County of Deat	1,075 h
- 1		Northwest Hospital Center Randallstown		Baltimo	
Funeral Director		216-54-3923 14 15 54 Yrs. 21 2	8. Date of Birth 10 (Month, Day, Ye Aug. 7	<b>251</b> 9 Birt 2005 Mar	hplace (State or Fore untry) 'Yland
pu y		Jsual Residence of Decedent  Oa. State 10b. County 10c. City, Town or Location			10d. Inside City Lim
within 72 nous atter beau with the maryland than "netural, or items 23a or 28a-f show" the Mudical Examinations is contiled at	- N	75 71 1			1 □ Yes 2√5√
28a-	ect	Maryland Baltimore Woodlawn  10e. Street and Number 10f. Zip Code	10a.	Citizen of What Co	untry?
Sa or	Funeral Director	28 Tomber Court 21207		USA	,
ms 2	era	11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spec	cify Yes or No-	14. Race - Ame	
ital Hygiene. nd other than "netural", or items 23a or 28a-f show event, the Medical Examinational be notified at	þ	Armed Forces? If Yes, specify Cuban, Mexican, Puerto R  1 Nover Married 2 Married 1 Yes, Sive 3 Widowed 4 Divorced  Armed Forces? If Yes, specify Cuban, Mexican, Puerto R 1 Yes, Sive 1 Yes, Sive 1 Yes Yes No Specify:	rican, etc.)	SpecifyBla	
Setur	Completed	15. Decedent's Education  16a. Decedent's Usual Occupation  (Give kind of work done during most of working	16b	. Kind of Business/	Industry
e. Mad	ple	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)		novvo 11	( X 7 C 7 )
Hygien other th	S	2 years Network Systems Engi		neywell	(NASA)
d oth	Be	17. Father's Name (First, Middle, Last)  18. Mother's Name  No. I good Abroah am T again		den Sumame)	
and Mental F	ဥ	Nelson Abraham Logan Pauline			
f Health and Mer Item 27 is marke other traumatic		19a. Informant's Name/Relationship (Type, Print)  Sharon Rae Logan/ Wife  28 Tomber Court Woo			
if Health Item 27 other tr				Location - City or	
nent o ant: If ury or		1 ⊠ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)  Arbutus Memorial Park	1/05		Maryland
Departi Import eny inf		21. Signature of Edheral Service License 22. Name and Address of Facility Cha 5240 Reisterstow	tman-Ha n Road	rris Fu Baltimo	neral Hore, Md 21
ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical Examiner	Due to (or as a consequence of):    Due to (or as a consequence of):			
ed by the attending phy detached for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	_	23d. Date of del Month	iivery Day Year
been signed t	Completed by Pl	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Acute Peuro Foultons	23e. Did tobacc	XXNo 356	the cause of death bably 4 Unknown
80	plet		24a. Was an autopsy performed	prior to death?	utopsy findings avail completion of cause 2 No
ate has b	mo				
ertificate has bo	0	25. Was case referred to medical examiner?	(Check only one)		
viter this certificate has but neral director, page 2 st	To Be	examiner?    Yes   2 No	(Check only one)  ne 5  Residence 8d. Describe how i		cify)
fler death. Vicector: After this certificate has b in by the funeral director, page 2 st	To Be	examiner?  1	ne 5 🗆 Residence	njury occurred	
4 hours after death. Funeral Director: After this certificately filled in by the funeral director.	Certification; To Be	examiner?    Yes   2 No	ne 5 ☐ Residence 28d. Describe how i 28f. Location (Stree City or Town, S	njury occurred  t and Number or Ritate)	ural Route Number,
nospiral or Attenting Frigoroan. A hours and acted death. Funeral Director: After this certificately filled in by the funeral director.	To Be	examiner?  1 Yes 2 No  Hospital: 1 Impatient 2 ER/Outpatient 3 DOA  Other: 4 Nursing Hom 22. Accordent 3 DOA  27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide  28a. Date of Injury 28b. Time of Injury Mork?  Mork?  M 1 Yes 2 No  28b. Place of Injury - At home, farm, street, factory, office  28c. Injury at Work?  M 1 Yes 2 No  28c. Place of Injury - At home, farm, street, factory, office  28c. Injury at 28c. Injur	Residence Reside	njury occurred  t and Number or Ri tate)  e(s) and manner as and place, and due	ural Route Number, s stated. to the cause(s)
to the nospital of steathing Firstonan. The same within 24 hours after death.  To the Funeral Director, After this certificate has be completely filled in by the tuneral director, page 2 st	Certification; To Be	examiner?  1 Yes 2 No  Hospital: 1 Impatient 2 ER/Outpatient 3 DOA  Other: 4 Nursing Hom 22. Accordent 3 DOA  27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide  28a. Date of Injury 28b. Time of Injury Mork?  Mork?  M 1 Yes 2 No  28b. Place of Injury - At home, farm, street, factory, office  28c. Injury at Work?  M 1 Yes 2 No  28c. Place of Injury - At home, farm, street, factory, office  28c. Injury at 28c. Injur	Residence Reside	njury occurred  t and Number or Ri tate)  e(s) and manner as and place, and due	ural Route Number, s stated. to the cause(s)
rospirator Attention of response. Funeral Director: After this certificately filled in by the funeral director.	Certification; To Be	examiner?    Yes   2 No	Residence Reside	njury occurred  t and Number or Ri tate)  e(s) and manner as and place, and due	ural Route Number, s stated. to the cause(s)

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State of Maryland / Department of Health and Mental Hygien 2 1 1 5

		1	For Stata Ragistrar	State of Marylan		nt of Health and Nete of Death	Mental Hygien		37818
7	Physicia		1. Decedent's Name (First, Middle, Last)	ernicele	(011)50	20 /	2. Date of Death Month Dovember	ay Year	3. Time of Death
1 ×	/Medic Examination Funeral Director	al er	4a. Facility Name (If not institution, give s.		OSP. 4b. City	Town, or Location of Death  Town, or Location of Death  Town, or Location of Death  Town, or Location of Death  Town, or Location of Death  Town, or Location of Death  Town, or Location of Death	8. Date of Birth (Month, Day, Yea	C. County of Death  O  9 Birth  County  O  County  County  O  County  O  County  O  County  O  County  O  County  O  County  O  County  O  County  O  County  O  County  O  County  O  County  O  County  O  County  O  County  O  County  O  Coun	
	Maryland		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Location	eltimo	۰		10d. Inside City Limits 1
	3a or 28	i Direc	10e. Street and Number 4306 E+	hland z	4-e 10f. zi	2120	7 109.0	Citizen of What Cor	untry?
920	n 72 hours after death with the Maryland "nature!", or items 23a or 28a-f ahow polical Examiner must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	2. Was Decedent Ever in U. Armed Forces? 1  Yes 2 No If Yes, Give Year or Dates:	S. 13. Was Dece If Yes, spe	dent of Hispanic Origin? (S ecity Cuban, Mexican, Puert 2000 Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Amer Black, White Specify:	
0-6171	na na	Completed	15. Decedent's Educ (Specify only highest grade	cation a completed)  Coflege (1-4or 5+)	16a. Decedent's Us. (Give kind of w life. DO NOT	ork done during most of wor	king 16b.	Kind of Business/I	Industry city Dept
/land z	uld be filed withir Mental Hygiene irked other then tic event, the Mi	To Be Co	17. Father's Name (First, Middle, Last)  Arthur	- Cho	imbers	18. Mother's Nar	ne (First, Middle, Maide	on Sumame)	~
Mar	nd 2 sho lith and P 27 is ma r trauma		19a. Informant's Name/Relationship (Ty)	_	1797-	s (Street and Number or Ru Hh (and Ave	iral Route Number, City Balto, v		
nore,	ages 1 and of of Healt t: if item 2 y or other t	1 7	20a. Method of Disposition  1 ☐ Burial 2 ☐ Gremation 3 ☐ R  4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Place of Disposition (Na emetery, crematory or	other place)	1 1	Location - City or	Town, State
Bartimo	permit, Pag Department Important: any njury o		21. Signature of Pytheral S. Vice Licens		22. Name a	and Address of Facility	XHILTON F	ass	md,21229
	Physician /Medical		23a. Part Eprer the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the deat le cause on each line.  Respira		de of dying, such as cardial			Approximate Interval Between Onset and Death
	Examiner		Sequentially list conditions,	Pneun	2001A				3 days
/pŋ,	ite be executed iysician and ne burial-transit	cal Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consec					
O. Box 68	death certifica e attending ph id for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 m/onths? 1 □ Yes 2 MNo 9 □ Unknown	3c. If yes, outcome of pregn 1 Live birth 2 Feta 4 Pregnant at time of c	al death 3 Ectopic			23d. Date of deli Month	ivery Day Year
<u> </u>	The law requires thet the de- ite hes been signed by the a bage 2 should be detached f	þ	Part II. Other significant conditions cor	ntributing to death but not res	sulting in the underlying	cause given in Part I.			the cause of death?
Il Records,		Completed					24a. Was an autopsy performed 1 Yes 2 V	prior to death?	utopsy findings available completion of cause of 2 No
Vita	ysicien: The l is certificate he director, page	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	lospital: 1 1 Inpatient 2	ER/Outpatient 3 🗆	Othor	ath Check only one Home 5 - Residence	6 □Other (Spe	afv)
Division of		atlon; T	27. Manner of Death 1 A Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. fnjury at Work? 1 Yes 2 No	28d. Describe how in		.,
Divis	of or Attandi after death. I Diractor: A d in by the fu	Certification;	3 Suicide 6 Could not be determined	28e. Pface of Injury - At h building, etc. (Special	ome, farm, street, factory)	ory, office	28f. Location (Street City or Town, St.		ural Route Number,
	To the Hospitel or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical C	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exami	sician: To the best of my kn ner: On the basis of examin- and manner stated.	owledge, death occurre ation and/or investigation	d at the time, date and place on, in my opinion, death occ	e, and due to the cause urred at the time, date a	(s) and manner as and place, and due	s stated. to the cause(s)
	To the within To the	Me	29b. Signature and title of central	1 M M	2	9c. License number	29d. 1	Date signed (Monti	h, Day, Year)
7	10		30. Name and address of person who co	ompleted cause of death (Item) 32. Figurer's Sign	m 23a) (Type, Print)	11 290 892	16 E DK 1	vovember	11,200
B.	Sta	ate	Sandra L. Swan  31. Date filed (Month, Day, Year)	n, M.D. Unit	on Memor	rial Hospita	u Salt	imore	7 1110
distr.	Regist		NOV 2 3 2	UUD Alesur	IN SUNDAN				

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	1	For State Registrar			Certificate of	Death		Reg. No	2005	3781
52		1. Decedent's Name (First, Middle, Last)	Lester	Hen	ry Løss Sr	•	2. Date of De	ath Da	y Year	3. Time of Death
Physician /Medical			Lester		1. (03)	· · · · · · · · · · · · · · · · · · ·	Noveml		21 200	911
Examiner	•	Aa. Facility Name (If not institution, give s  The Control of the	treet and number)  V 7 5 1 1 2 9  7. Age lin yrs	en -	ter Ba	If Under 24 Hrs.	ve		. County of Dea	th thplace (State or Fore
Funeral Director			M 2□F 87		rs. Months Days	Hours Min.	8. Date of Bir (Month, Da Oct. 1	6,	1918 Per	insylvania
rahow so at		10a. State 10b. County			or Location					10d. Inside City Limi
natural', or items 23a or 28a-1 show disal Examinat must be untified at sted by Funeral Director		Maryland N/A  10e. Street and Number		<u>ltim</u>	10f. Zip Code				tizen of What Co	ountry?
s 23s		1243 Pine Heights		1.0	212		andy Van as No		JSA 14. Race - Ame	orcan Indian
if, or item transferra		11. Marital Status  1 □ Never Married 2 □ Married  3 및 Widowed 4 □ Divorced	12. Was Decedent Ever in I Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give	0.5.	13. Was Decedent of H If Yes, specify Cuba  1 ☐ Yes 2 ☑ No	an, Mexican, Puerto Specify:	Rican, etc.)	)-	Black, Whit	
al Ex		15. Decedent's Educ	Year or Dates:	16a	Decedent's Usual Occup	ation		16b K	(ind of Business	/Industry
ygiene. nerthan "naturi it, the Medical is Completed		(Specify only highest grade		100.	(Give kind of work done life. DO NOT use retired	during most of world)	king		ıto Part	,
Hygie ther int.		12 17. Father's Name (First, Middle, Last)			Service le	18. Mother's Nam	ne (First, Middle			.S
Mental H arked ott atic even	í	Andrew	Loss			Alma			Baker	
and is ma		19a. Informant's Name/Relationship (Type Charles O. Loss, S	1 .		Mailing Address (Street D Box 348,				or Town, State, .	Zip Code)
in of Health	-	20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ R  4 ☐ Donation 5 ☐ Other (Specify)	emoval from State B	Place of cemeters	Disposition (Name of c, crematory or other place of nore Crematory of the place of the control	ory 11/2	Date		ocation - City or	Town, State Maryland
Department of Important: If I any njury or ones.	Ī	21. Signature of Funeral Service Licens		Loui	22. Name and Addre				Funeral	
any one	1				3620 Wilk					
hysician /Medical		shock, or heart lailure. List only one cause on each line.								Approximate Interval Between Onset and Death
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od for u	iyarcımınını	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify) _	<i>y</i>			23d. Date of de Month	livery Day Year
po eq	2	Part II. Other significant conditions con	tributing to death but not re	sulting in	the underlying cause give	ren in Part I.		lobacco Yes 2		o the cause of death
rine law requires triat free cate has been signed by the page 2 should be detache.	andida.							psy ormed?/	death?	utopsy lindings availa completion of cause
		25. Was case relerred to medical				26. Place of Dea	1 ☐ Yes	2 No	o 1 L Yes	2 □ No
0 0	וב	examiner?	lospital: 1   Inpatient 2	⊒ ER/Out	patient 3 DOA Oth	100			6 ☐Other (Spe	cify)
After	asion.	27. Manner of Death  1  Accident   Second   Pending   28a. Date of Injury (Month, Day Year)   28b. Time ol Injury at Work?  2  Accident   Accid						28d. Describe how injury occurred		
rs after death.	2011112	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, lai	rm, street, lactory, office		28l. Location ( City or To	Street ai wn, Stat	nd Number or R e)	ural Route Number,
Funer Funer		29a. Certifier 1 Certifying Physical Check only one) 2 Medical Examin	sician: To the best of my kiner: On the basis of examinand manner stated.	nowledge nation and	, death occurred at the tradfor investigation, in my o	me, date and place opinion, death occu	, and due to the rred at the time,	cause(s date an	s) and manner as od place, and due	s stated. e to the cause(s)
within 2 To the complete	IAI	29b. Signature and title ol certifier	my)	Mo	29c. Licens		1		ember	
4		30. Name and address of person who co	empleyed cause of death (Its	Α	Type, Print)  NUE, 15	altimo	ire, N	lar	ylama	22,200
State Registrar		31. Date filed (Month, Day, Year)	32 Registrar's Sig	nature	Scartie)			ı		

State of Maryland / Department of Health and Mental Hygiene 0 0 5 37820 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death No V.  $2^{\text{Day}}$ **Physician** 2005 Melba Irene Landes 6:00 a M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Carroll Hospital Center Carroll Westminster 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Nonths | Days | Hours | Min. | Feb. | 15, 1524 9. Birthplace (State or Foreign Country)
M1SSOUri 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 □ F 490-20-9513 Director Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or than "natural", or Itams 23a or 28a-f show the Medical Examiner must be nutilied at 1 Yes 2 No Sparks Directo Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 88 Far Corners Loop 21152 U.S.A. Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filled within 72 hours atternent of Health and Mental Hygiene.
ant: If item 27 Is markad other than "natural", or Itaury or other traumatic evant, the Medical Evantural. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ Specify: White 3 

Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Administrative Secretary State of Maryland 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Andrew Timothy Light Lydia Southard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 88 Far Corners Loop, Sparks, Md. 21152 Charles Landes - son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a, Method of Disposition 20c. Location - City or Town, State 1 ☐ Surial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or once. Lakeview Mem. Park Nov. 26,2005 Sykesville, Md. \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Eckhardt Funeral Chapel P.A.
11605 Reisterstown Rd. Owings Mills, Md. 21. Signature of Funeral Service Licensee Last Eller 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Intarction Myocardial Acute **Physician** /Medical Due to (or as a consequence of): **Examiner** Cardinaenic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequent e of): Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy signed by the atte Month Year Day 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Advance 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 46 24a. Was an page 2 s autopsy performed? 1 🗍 Yes 2 DK To the Hospital or Attending Physician: 25. Was case referred to medical examiner? the funeral director, 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a
To the Funeral C
completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medicai 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 039502 HD MILIOT 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 447. East Main St. Westwinsters MD 21157 HOSKIN MA 31. Date filed (Month, Day, Year) 32. Pagistrar's Signature State NOV 2 3 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene 0 0 5 1 State Certificate of Death

37821

			Registrar				Cer	uncate of	Dealli		Reg. No.		
	Physici /Medic		1. Decedent's Nam	e (First, Middle, La	•	ginia	May L	ochstampl	hfor	2. Date of De Month Novemb	Day Der 20,	Year 2005	3. Time of Death 6:35 P M
	Examin		4a. Fecility Name (	If not institution, giv	4b. City, Town, o	r Location of Death		4c. County	of Death				
			Glade Valley Nursing Home						sville		Fred	erick	
	Funeral Director		5. Social Security N 214-32-9		Sex 7. Age (In yrs. last birthda) 1 M 2 X F 88 Yrs.			If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year)  July 6, 1917 N		9. Birthp Coun Mar	place (State or Foreign otry) yland
	and w		Usual Residence o 10a. State	f Decedent 10b. County		10c City	Town or Lo	cation				1	Od. Inside City Limits
	Aaryla F sho	ō	MD	ick	Middletown							1 ☐ Yes 2 ☑ No	
	the A	Director	MD Frederick  10e. Street and Number				MIGGI	10f. Zip Code			10g. Citizen of What Country?		
	3a or	Ö		ed Rose C	ourt				1769			USA	, 1
	death ms 2	Funerai	11. Marital Status		12. Was Deceder		. 13. \		dispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No		ce - Americ	an Indian,
9	after or Ita		1 Never Marr	1 Never Married 2 Married 1 Yes			2 <b>X</b> No			Rican, etc.)		ck, White,	
Maryland 21215-0036	72 hours after death with the Maryland natural", or Itams 23a or 28e-f show liteal Examinat must be notified at	d by	3X Widowed	4 Divorced	If Yes, Give Year or Dates	s:		1 ☐ Yes 2 <sup>A</sup> No	Specify:		Specif	γ: W11.	ite
5-(	natu	Completed	(Spec	15. Decedent's E cify only highest gra			16a. Deced	dent's Usual Occup kind of work done	ation during most of work	ing	16b. Kind of B Burtons		•
7	withir ene than	dmc	Elementary/Second 12t1	Elementary/Secondary (0-12) College (1-4or 5				(Give kind of work done during most of workir life. DO NOT use retired)  Postmaster				ffice	е
<b>d</b> 2	filed Hygi othar ant, t	a l		(First, Middle, Last,						ne (First, Middle, Maiden Sumame)			
lan	lid be lental kad ic ev	To B	Frankli	n Pierce	Wootten				Annie				
ary	shou and M s mar umat	-	19a. Informant's N	ame/Relationship (	Type, Print)		19b. Mailin	g Address (Street	and Number or Rur	al Route Numb	er, City or Town,	State, Zip	Code)
Σ	alth alth a		Sandra 1	L. Nicoul	in/Daught	er	4409	Red Rose	e Court,	Middlet	own, MD	217	69
ore	es 1 and Med Helphan		20a. Method of Dis	•	Removal from Star	0.00	ce of Dispo	sition (Name of natory or other place	ce)	Date	20c. Location -	City or To	wn, State
Ĕ	Pag ment ant: I ury o			5 Other (Special			on Ce	metery	11/2	3/2005	Burtons	svill(	e, MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Important: If item 27 is marked othar than "natural", or Itams 23a or 28e-f show any injury or other traumatic evant, the Medical Examinar must be notified at once.		21. Signature of Fu	uneral Service Lice	1/0				ss of Facility DO			L Home	e, P.A.
_	<u></u> <u> </u>		X MU	the pro-	le you	M00773			t Avenue			20707	
			shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death
	Prrysician : /Medical	97.3	Immediate Cause disease or condition resulting in death)	on	Vulvar Cancer								Months
	Examiner		, , , , , , , , , , , , , , , , , , , ,	- (	Due to (or as a consequence of):								
		e	Sequentially list co	nmediate 📕	b. Due to (or a	as a consequence of):							
1	uted d ansit	Examine	cause. Enter Under that initiated events	erlying									
Ó	certificate be executed Iding physician and Ise as the burial-transit		resulting in death)	Last	Due to (or a	as a conseque	ince of):						
68760,	ate be nysici he bu	an/Medicai			d								
39 )	artifica ing ph e as t	Med	IF FEMALE:										
Вох	C = -	ian/	23b. Was decedent pregnant    1								23d. Dai	te of delive	ry Day Year
0	0 0	Physici	1 ☐ Yes 2) 9 ☐ Unknown	No	4∐Pregnant 9□ Unknown	at time of dea	ith 5∟	Other (specify)					ou, rou.
α.	that the led by th detache	/Ph	Part II. Other signi	ficant conditions	contributing to death	but not result	ing in the ur	nderlying cause give	en in Part I.	23e. Did t	obacco use cont	ribute to th	e cause of death?
ds,	requires leen sign hould be	d by								1 🗆	Yes 2⊠No	3 Proba	ably 4 Unknown
Vital Record	w requir s been si should	Completed								24a. Was	an 24b. \	Were autor	osy findings available
Re	The law cate has b page 2 sl	dmo								autor	psy prmed?	prior to com death?	npletion of cause of
ital		O	25. Was case refer	red to medical					26. Place of Deati	1 ☐ Yes		1 🗆 Yes	2 <b>X</b> ] No
<b>&gt;</b>	\$ S F	To B	examiner? 1 Tes 2	₹No	Hospital: 1 ☐ Inpa	tient 2 El	R/Outpatien	t 3 DOA Oth	er: 4 <b>X</b> Nursing Ho			er (Specify	)
on of	Attending Ph ir death. actor: After th by the funeral	Certification:	27. Manner of Deat  1 Autural  2 Accident	th 5 Pending investigation	28a. Date of In (Month, L	jury 2 Day Year)	8b. Time of Injury	28c. Injun World		28d. Describe	how injury occurr	ed	
Division	Atter r dea actor by the	ifica	3 🗌 Suicide	6 Could not b	e 28e. Place of I	njury - At hom	ne, farm, stre	eet, factory, office		28f. Location (Street and Number or Rural Route Number.			
Ö	al or A s after al Dira	Cert	4 Homicide building, etc. (Specify)  City or Town, State)										
	To the Hospital or Attending Phwithin 24 hours after death. To the Funaral Diractor: After th completely filled in by the funeral	Medical (	29a. Certifier (Check only one)	1 Certifying Ph 2 Medical Exer	nysician: To the bes niner: On the basis and manner:	of examinatio	edge, death n and/or inv	occurred at the timestigation, in my of	ne, date and place, pinion, death occurr	and due to the ed at the time,	cause(s) and ma date and place, a	nner as sta and due to	ated. the cause(s)
	To the within 2 To the complet	Ĭ.	29b. Signature a	title of certifier				29c. License	e number		29d. Date signed	1 (Month, E	Day, Year)
			▶ \q	41/2				D265	16		Novemb	er 21	, 2005
	12				completed cause of			*					
	10			len Gilso				ie, Frede	rick, MD	2170	L		
	Sta Registr		31. Date filed (Mon			strar's Signatui	_	. M.					
DH	MH 17 Rev 1/20		N	OV 2 3 20	185	w B	1						
		1											

			For	State of Ma		d / Depa	artment o	f Health a	and M	ental Hyg		egible.		
			1 - Stata Registrar			Cei	rtificate d	of Death		F	leg. Ng	005	37822	
П	Physici	an	1. Decedent's Name (First, Middle,							Date of Dea     Month	th Day	Year	3. Time of Death	
	/Medic	al		SHARON L	EE L	מאט				NOV.			1:35 P M	
	Examin	er	4a. Facility Name (If not institution,		7 T) CT	1		m, or Location of				•		
			81 PENNSYLVAN  5. Social Security Number			ast birthday)	WEST If Under 1 Ye	MINST		8 Date of Birth				
	Funeral Director		218-52-4840	1 □ M 2½ □ F	56	Yrs.		ys Hours	Min.	8. Date of Birth (Month, Day 6 / 9 / 1	Year)	DE	ountry)	
	P.		Usual Residence of Decedent		,					0/5/1.			MADILIVANIA	
	arylar show	<u>_</u>	MD 10b. County CARF	OT.T.		/, Town or Lo ESTMII								
	he M	ecto			AAT	2011411								
	with a or 3	by Funeral Director	10e. Street and Number 81 PENNSYLVAN	T	שת ע	1	10f. Zip Coo					n of What C	ountry?	
	death	era	11. Marital Status	12. Was Decedent	Ever in U.S		2115 Was Decedent		gin? (Spe	cify Yes or No-		. Race - Ami	erican Indian	
ထ	or Iter	Ē	1 ☐ Never Married 2 ☐ Marrie	Armed Forces? d 1 ☐ Yes 2 🔯 I		1				cify Yes or No- Rican, etc.)				
93	ral', c	1 by	3 ☐ Widowed 4 ☑ Divorced	If Yes, Give Year or Dates:			1 ∐ Yes 2X	No Specify:			St	pecify: W	HITE	
21215-0036	within 72 hours after death with the Maryland ane. than 'natural', or Items 23s or 28a-1 show the Macinal Examiner must be notified at	Completed	15. Decedent's (Specify only highest	Education grade completed)		16a. Deced (Give	dent's Usual Oc kind of work do	cupation one during most tired)	t of workir	ng	16b. Kind	of Business	/Industry	
12	within and the state of the sta	du l	Elementary/Secondary (0-12)	5+)		OME MA			i i	asath Day Year 19, 2005 1:35 P M  4c. County of Death CARROLL  Inth ay, Year) 9. Birthplace (State or Foreign Country) PENNSYLVANIA  10d. Inside City Limits 1 M Yes 2 No  10g. Citizen of What Country?  USA  14. Race - American Indian, Black, White, etc.  Specify: WHITE  16b. Kind of Business/Industry  PRIVATE HOME  Maiden Sumame)  WHAVOWN  PERCO, MD.  17. PRIVATE HOME  MINSTER, MD. 21157  20c. Location - City or Town, State  UPPERCO, MD.  FUNERAL HOME  MINSTER, MD. 21157  Approximate Interval Between Onset and Death  23d. Date of delivery Monet and Death  24b. Were autopsy findings available prior to completion of cause of death? Yes 2 No  an Death Day Year  24b. Were autopsy findings available prior to completion of cause of death? Yes 2 No  an Death Day Year  24b. Were autopsy findings available prior to completion of cause of death? Yes 2 No  an Death Day Year  25dence 6 Other (Specify)  how injury occurred  Street and Number or Rural Route Number, Wrn, State)  Cause(s) and manner as stated.  date and place, and due to the cause(s)				
d 2	Hygie thar	ပိ	1 2 17. Father's Name (First, Middle, Li	ıst)			OME MA		r's Name				OME	
an	id be ental kad c	To Be	G	EORGE RUS	SELL	HALE			ILEN				IOWN	
Maryland	shou and M smar umat		19a. Informant's Name/Relationshi	o (Type, Print)		19b. Mailin	g Address (Str				, City or T	own, State, .	Zip Code)	
Ž	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked othar than "natural; or items 23a or 28a-1 show apprintury or othar traumatic event, the Madical Examinat mat be notified at once.		LINDA NAYLOR	- COUSIN										
Baltimore,	of He		20a. Method of Disposition  ∑ Burial 2 ☐ Cremation 3	I □Removal from State	20b. PI	ace of Dispo	sition (Name or natory or other	1						
Ĕ	Pag ment ant:		□ Donation 5 □ Other (Spe	icify)	FOR	EST B	APTIST	CEM.	11/2	2/05 t	PPE	RCO,	MD.	
3all	permit Depart Import any in		21. Signaturn of Sure et al.	censee										
	FOREG				4 46							LER,		
Г	- E- E- E- E-		23a. Part 1. Enter the disease, or c shock, or heart failure. List or Immediate Cause (Final	nly one cause on each lin	10.	. Do not enti	er the mode of	/					Interval Between	
	Pnysician /Medical	6.1	disease or condition resulting in death)	a. ///	COY	1777	C (1)	0~	CA	~ Co				
	Examiner			Due to (or as	a consequ	ience or):								
		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	a consequ	nsequence of):									
V	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funaral Director: After this certificate has been signed by the attending physician and completely tilled in by the tuneral director, page 2 should be detached for use as the burial-transit		that initiated events											
8760,	oe execian a	EX	resulting in death) Last	Due to (or as	a consequ	rence of):								
876	physic physic the b	dical		d										
9 xo	death certific attending p	Physician/Med	IF FEMALE:	23c. If yes, outcome	of pregnar	ncv								
മ	atten aften I for u	cian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)						230				
o.	t the c achec	hysi	1 Yes 2 No 9 Unknown	9□ Unknown										
o,	uires that the de signed by the a Id be detached f	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tob	acco use	CARROLL  9. Birthplace (State or Foreign Country) PENNSYLVANIA  10d. Inside City Limits 1 X Yes 2 No  Ditizen of What Country?  SA  14. Race - American Indian, Black, White, etc.  Specify: WHITE  Kind of Business/Industry  IVATE HOME an Surname)  UNKNOWN  FOR TOWN, State, Zip Code)  MD. 21157  Location - City or Town, State  PERCO, MD.  JINERAL HOME Interval Between Onset and Death  23d. Date of delivery Month Day Year  Puse contribute to the cause of death? 21 No 3 Probably  24b. Were autopsy findings available prior to completion of cause of death? 21 No 3 Probably  24b. Were autopsy findings available prior to completion of cause of death? 21 No 3 Probably  24b. Were autopsy findings available prior to completion of cause of death? 21 No 3 Probably  24b. Were autopsy findings available prior to completion of cause of death? 25 No 3 Probably  24b. Were autopsy findings available prior to completion of cause of death? 25 No 3 Probably  25 No 3 Probably  26 Other (Specify)  17 Unknown		
ord	w require been sig should b	ted								1 □ Y€	s 2 🗆 N	lo 3□Pr	obably 4 Unknown	
Records,	law r las be	Completed								24a. Was a				
<u>ه</u>	: The cate t	Col								perform	ned?	death?		
Vital	sician: The law certificate has b irector, page 2 s	Be	25. Was case referred medical examiner?	Hospital:				Othor		(Check only on				
	ding Physician: The Ih. After this certificate hat funeral director, page	.: To	1 Yes 2 No	1 Inpatie		ER/Outpatient 28b. Time of	3 DOA	4 🗆 1401	rsing Hor				cify)	
lon	nding Ith. :: Afte e fune	ation	Natural 5 Pending 2 Accident investiga	28a. Date of Injui (Month, Day	Year)	Injury		njuryat Work? □Yes 2□N			in injury or	Jodin Ju		
Division of	after death after death Diractor: I in by the	Certification:	3 Suicide 6 Could no 4 Homicide determin		ury - At hor	me, farm, stre	et, factory, office	се	2	8f. Location (Str	reet and N	umber or Ru	ıral Route Number,	
۵	rs after and real or and real	Cer		Dulldling, etc	s. (Openly)					City of TOWN	, State)			
	To the Hospital or Attand within 24 hours after death To the Funeral Director: completely filled in by the	icai	(Check only 2 Medical E)	Physician: To the best of the basis of	of my know examinati	vledge, death	occurred at the	e time, date and	d place, a	nd due to the ca	use(s) and	d manner as	stated.	
	tha tha tha tha tha tha mplet	Medicai	29b. Signature and title of certifier	and manner sta	ited.			ense number						
	5 1 × 1		25D. Signature and title of	\				530	7	1		/ /		
			30. Name and ordes of person wi	no completed asuse of d	eath (Item	23a) (Type 1		_						
	2		YOURAF A.	Battar	5	55	5. Cen	ter S	tres	et We	stm	instr	C. MO DIN	
	Sta		31. Date filed Month, Day, Year)	32. Begistra	ar's Signati			· · ·					THE OTHER	
1	Registr	ar	NOV 2 3	2005	_ 8	2 An	wife !							

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** MARY Month /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 7808 Harbor Rd Pasadena Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2000F Director 73 214-26-4583 1932 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 28a-f ehow 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 No MDAnne Arundel Pasadena 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 7808 Harbor Rd Itema 23a 21122 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 72 hours after 1 ☐ Yes 2 📆 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 5 1 ☐ Yes 2 ☑ No Š Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced "natural", White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Carrick Elizabeth Hackett ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Itam 27 I William Meade Husband 7808 Harbor Rd, Pasadena, MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of I-Important: If Its any injury or of once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Spacify) Maryland Veterans Cem Nov 28, 2001 Crownsville, MD 21. Spriture runeral Service 1 ee Fink Funeral Home, P.A. 426 Crain Hwy Sw, Glen Burnie, MD M01148 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CANCER disease or condition resulting in death) MO-12 /Medical Due to (or as a consequence of): Examiner inbates Securitally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certilicate be executed ettending physicien and for use as the burial-transit socholar Due (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death signed by the e 5 Other (specify) o. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by been si 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? cate has page 2 s autopsy performe his certificate h I director, page 1□ Yes 2 No 1 🗌 Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ို 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA this After thi funeral of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Medical Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the within 24 hours efter deat To the Funeral Director: 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 014751 Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Signature State 3 Registrar

sign and the		<ul> <li>State Registrar</li> <li>Decedent's Name (First, Middle, Last)</li> </ul>		Cei	rtificate of De	eath	2. Date of De	Reg. No.2	05	37821
Physici /Medic		MARY ANNA MACCAUL	EY				Month NOV	Day	Year 2005	1:40 P M
Examin	eŗ	4a. Facility Name (If not institution, give s		Lu_	4b. City, Town, or Lo	cation of Death		4c. County		
		HAMMONDS LN GENES  5. Social Security Number 6. Sex	EARE e (In yrs. last birthday)	BROOKLYN  If Under 1 Year If	Under 24 Hrs.	8. Date of Bir		ANNE ARUNDEL		
Funeral Director			M 2□ F	92 Yrs.		Hours Min.	JUNE 6	y, Year)		lace (State or Foreigr try) <b>NY</b>
s i and a should be lied within /z frouts arier death with the maryland if Health and Menital Hygione if Health and Menital Hygione if the 27 is marked other than "natural; or items 23a or 28a-f show other traumatic event, the Medical Exeminar must be notified at	or	10a, State 10b. County		10c. City, Town or Lo					10	0d. Inside City Limits  1 Yes 2 No
28a-i	Director	MD ANNE ARU	NDEL	BROOKLY	BROOKLYN  10f. Zip Code					itry?
38 or		613 HAMMONDS LN		21225			US	SA		
ma 2	Funeral		12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of Hispa If Yes, specify Cuban, I	anic Origin? (Sp Mexican, Puerto	ecify Yes or No		ce - America	
a B	y Fu	1 Never Married 2 Married	1 ☐ Yes 2 XXX If Yes, Give	No.	1 ☐ Yes 2 ☐ No 5	Specify:		Specif	5v.	
EX	d by	3 Widowed 4 □ Divorced	Year or Dates:	160 Dags	XX				MHT	
odica	Completed	15. Decedent's Educ (Specify only highest grade	completed)	(Give	dent's Usual Occupation  kind of work done duri  DO NOT use retired)	ing most of work	ung	16b. Kind of B	usiness/ind	dustry
N eg	mo	Elementary/Secondary (0-12)	College (1-4or 5	i+)	EAMSTRESS			GARMI	ENT	
ent,	Be C	17. Father's Name (First, Middle, Last)				3. Mother's Nam	e (First, Middle	, Maiden Surnar		
tic ev	To B	JOHN LIBERA				SUSAN 1	KACZMOC	ZICK		
is marked other than aumatic event, the M		19a. Informant's Name/Relationship (Type			ng Address (Street and				, State, Zip	Code)
n 27 ser tr		JOHN F. LIBERA	BROTHER		INDIANA AV					
		20a. Method of Disposition  Burial 2 □ Cremation 3 □ R	emoval from State		natory or other place)		Date	20c. Location	,	
in's		Burial 2 Cremation 3 R	-	<b>n</b>	N CEMETERY		3.2005	GLEN I	BURNII	E, MD
any injury or		21. Signature of Fuheral Service License  K. GREGORY FIN	04~	F	Name and Address of INK FUNERA  26 CRAIN H	L HOME,		NTE MIN	21061	1
<u>*</u>		23a. Part1. Enter the disease, or comolishock, or heart failure. List only on			er the mode of dying, s	such as cardiac	or respiratory a	rrest,	21001	Approximate Interval Between
ian		Immediate Cause (Final disease or condition	C	<1.	Dem					Onset and Death
lical		resulting in death)	Due to (or as	a consequence of).	- Jew	Hans				
ner										
=	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		a consequence of):						
buriai-transii	Examiner	Cause (Disease or injury that initiated events resulting in death) Last								
3	al E	Tosaking in additify cast	Due to (or as	a consequence of):						
	dice		J							
for use as the t	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome	of pregnancy		23d. Date of delivery				
į	clar	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at		Ectopic pregnancy Other (specify)					Day Year
	hysl	9 Unknown	9□ Unknown							
	by P	Part II. Other significant conditions con	tributing to death b	ut not resulting in the u	ndertying cause given i	in Part I.	23e. Did t	obacco use conf	tribute to th	e cause of death?
2	edi						1 🗆 '	Yes 2□No	3 🗌 Proba	abty 400 inknown
DINOUS Z	Completed						24a. Was	an 24b.	Were autop	osy findings available impletion of cause of
n de de	mo:						perfo	ormed? 2.20No	death?	2 <b>27</b> No
director, page 2	Be	25. Was case referred to medical examiner?			20	6. Place of Deat				
5	To	1 Yes 2 No	lospital: 1   Inpatie	ent 2 ER/Outpatier			me 5 Resi	dence 6 □Oth	ner (Specify	<i>'</i> )
unera		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Inju (Month, Da	ry Year) 28b. Time o	Work?		28d. Describe	how injury occur	red	
<u> </u>	cati	Accident investigation  Suicide 6 Could not be				s 2 No				
•	Certification;	4 Homicide determined	28e. Place of Inj building, et	ury - At home, farm, sti c. <i>(Specify)</i>	reet, factory, office		28f. Location (: City or To:	Street and Numb wn, State)	ber or Rural	l Route Number,
-		29a. Certifier 1 Certifying Phys	sician: To the best	of my knowledge, deat	n occurred at the time,	date and place,	and due to the	cause(s) and ma	anner as sta	ated.
completely filled in by the funeral	Medical	(Check only 2 Medical Examile one)	ner: On the basis of and manner sta	f examination and/or in ated.	vestigation, in my opini	ion, death occur	red at the time,	date and place,	and due to	the cause(s)
COM	Σ	29b. Signature and title of certifier			29c. License n	umber		29d. Date signe	d (Month, E	Day, Year)
		1500		MD	D	53465		u\	21/0	
1		30. Name and address of person who co	mpleted cause of d	leath (Item 23a) (Type,	Print)			•		-
9		Jude Muneses		845 OA	Kwood R	COAD C	olen Bi	whie m	0 2	31061
Sta		31. Date filed (Month, Day, Year)	32. Hegistr	ar's Signature	7					
Registi		00	105 1000	M. C.	DRAGI					

			1 - For State Registrar	State of	Maryland / Depa	artment of Healtl	th	
			Decedent's Name (First, Middle	, Last)			2. Date of De	
	Physici /Medi		LAVERNE HOLT M	OORE			NOVEMB	ER 22, 2005 9:25 A M
	Examir		4a. Facility Name (If not institution	, give street and num	iber)	4b. City, Town, or Location		4c. County of Death
			1209 CATHEDRAL			GLEN BURNI		ANNE ARUNDEL
	Funeral Director		5. Social Security Number 572.42.8651	6. Sex 1 M 2 F	7. Age (In yrs. last birthday) Yrs.	If Under 1 Year If Un Months Days Hou		th 9. Birthplace (State or Foreign Country)  1935  MICHIGAN
	p .		Usual Residence of Decedent		100 City Town			
	ehow	5	10a. State 10b. County		10c. City, Town or Lo	ocation		10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	28a-f	Director	NC FORS	YTH	WINSTON-S	ALEM 10f. Zio Code		XX
	with with							10g. Citizen of What Country?
	ne 23	Funeral	11. Marital Status	12. Was Dece	dent Ever in U.S. 13.	27107 Was Decedent of Hispanic	Origin? (Specify Yes or No	USA 14. Race - American Indian,
ပ္	72 hours after deeth with the Maryland neture!', or iteme 23a or 28a-f ehow distal Exarclinat the motified at	표	1 Never Married 2 Marri	Armed Fore	ces? 2 <b>1∑1x</b> 1o	If Yes, specify Cuban, Mexi	ican, Puerto Rican, etc.)	Black, White, etc.
8	rel', c	l by	3 Widowed 4 □ Divorced	If Yes, Give Year or Da	,	1 ☐ Yes 2 ☐ No Spec XX	city:	Specify: WHITE
21215-0036	within 72 hours after deeth with the Milene. liene. r than "neturel", or iteme 23e or 28e-f The Medical Exarciner must be muitible.	Completed	15. Decedent (Specify only highes	's Education t grade completed)	16a. Dece	dent's Usual Occupation kind of work done during n	nost of working	16b. Kind of Business/Industry
121	within ene. than "	Id II	Elementary/Secondary (0-12)	College (1-	life.	DO NOT use retired)		
2			12 17. Father's Name (First, Middle, I	act)	TELE	PHONE OPERAT	'OR other's Name (First, Middle	TELECOMMUNICATION
and	id be f ental h ked of	Be				10. MC	ALICE A. K	,
Maryland	s 1 and 2 should be filed f Health and Mental Hyg Itam 27 ts marked othe other traumatic event,	၉	BARNEY ALLEN H  19a. Informant's Name/Relationsh		19b. Maili	ng Address (Street and Nur		er, City or Town, State, Zip Code)
S	and 2 sealth ar n 27 is		PATRICIA BOND					RNIE, MD 21061
<u>6</u>	s 1 and if Health item 27 other tr		20a. Method of Disposition		20b. Place of Dispo	sition (Name of	Date	20c. Location - City or Town, State
e E	Page ento nt: if ry or		1 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (St	3 Removal from S	1819	matory or other place)	11 20 2005	TITIO TO THE TOTAL AND THE TOT
Baltimore,	- 0 O - mi		21. Signar a of Funeral Service		) Z	MEMORIAL PK.  Name and Address of Fa	cility	WINSTON-SALEM, NC
Ö	Per lang		No Parties	FUNK, DR		NK FUNERAL H	OME, P.A. SW GLEN BURN	TE MD 21061
				complications that ca	used the death. Do not ent	er the mode of dying, such	as cardiac or respiratory a	rrest, Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	1	Train 0 (	Conce		Onset and Death
7	/Medical		resulting in death)	a. Due to (c	or as a consequence of):	(12) (X)		745
	Examiner		Sequentially list conditions,	b				
	D #	Iner	it any, leading to immediate cause. Enter Underlying	Due to (a	r as a consеquence of):			
6	and and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c				
80,	cian a		Todaking in dodkiny zadi	Due to (o	r as a consequence of):			
,0928	ficate be executed physician and s the burial-transit	dicai		d				
w	± 0, α	(a)	IF FEMALE:	23c. If yes outc	ome of pregnancy			
Вох	death certif e attending id for use as	cian	23b. Was decedent pregnant in the past 12 months?	1 Live bir	th 2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)		23d. Date of delivery  Month Day Year
	0 0 0	Physician/M	1 □ Yes 2 <del>□ V</del> o 9 □ Unknown	9□ Unknov		Other (specify)		
	requires that the teen signed by th hould be detache	by Pt	Part II. Other significant condition	ns contributing to dea	th but not resulting in the u	nderlying cause given in Pa	urt I. 23e. Did to	obacco use contribute to the cause of death?
Sp	iw requires that s been signed t s should be det						10	Yes 2 No 3 Probably 4 Unknown
8	> 10 0	Completed					24a. Was	an 24b. Were autopsy findings available
Be	0 - 0	E O					autor perfo	prior to completion of cause of death?
ta	ician: Th certificate rector, pag	0	25. Was case referred to medical			26 Pl	1 ☐ Yes	2 No 1 Yes 2 No
≥	d s	To B	examiner? 1 Tes 2 No	Hospital:	patient 2 ER/Outpatien	Other	1 1	dence 6 □Other (Specify)
0	ng Phy ter thi neral		27. Manner of D	28a. Date of	Injury 28b. Time of Injury		28d. Describe i	now injury occurred
Ö	Attending in death. ector: After by the fune	atic	1	ation	, say roar, injury	M 1 ☐ Yes 2	□No	
Division of Vital Records,	ii or Attend efter death Director: , d in by the f	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 286. Place o	of Injury - At home, farm, str g, etc. (Specify)	eet, factory, office	28f. Location (S City or Tow	Street and Number or Rural Route Number,
	ital or irs efte rai Dir iled in		XX					
	Hosp 4 hou Fune Fune	ca	Check only 2   Medical E	:xaminer: On the bas	sis of examination and/or in	occurred at the time, date restigation, in my opinion, d	and place, and due to the death occurred at the time.	cause(s) and manner as stated. date and place, and due to the cause(s)
	To the Hospital or Attending Ph within 24 hours eliter death. The Funeral Director: After th completely filled in by the funeral	Medical	29b. Signature and title of certifier	and manne	er stated.	29c. License numbe		
	F ≥ F 8		23. Signature and the Great lines	12ho	//	The same of the sa	1 12/	29d. Date signed (Month, Day, Year)
	1		30 00 00 00	1/2		~3	,	/VOVEmber 23,2005
	6		30. am and address of person v	le with 3	of death (Item 23a) (Type,	ELINE)	ie Chain	November 23,2005
	Sta	te	31. Date filed (Month, Day, Year)	32.	istrar's Signature	10.101 m	21110	my ws civel
	Registr		NOV 9 5	2005	le A			

			For State Registrar	State of	Marylan		artment rtificate			ınd M	_	giene Reg. No.	005	37826
	Physici /Medic	al	1. Decedent's Name (First, Middle, Patricia Con. 4a. Facility Name (If not institution,	suelo 1		overn	4b. City, To	wo or l	ocation o		2. Date of De. Month November	Day 13	Year 2005 County of Deal	
	Examin Funeral Director	er	Howard County 5. Social Security Number	General Ho	spital	last birthday) Yrs.	Co]	Lumb		24 Hrs. Min.	8. Date of Birt (Month, Da Apr 4,	h y, Ye <i>ar)</i>	Howard 9. Bin	
	p.	tor	314-44-6925  Usual Residence of Decedent  10a. State 10b. County  MD Howa	ırd	10c. Cit	y, Town or Lo					API 4,	1344	I IN	10d. Inside City Limits 1 ☐ Yes 2√ No
	2 should be filed within 72 hours after deeth with the Maryland and Mental Hygiane.  Is marked other than "natural", or items 23s or 28s-f show aumatic event, the Modical Examiner must be notified at	Funeral Director	10e. Street and Number 6336 Cedar Lan 11. Marital Status	12. Was Decede Armed Force	s?	.S. 13. \	10f. Zip Co Was Deceder 1 Yes, specify	2	1044 panic Orig , Mexican	gin? (Spe , Puerto F	cify Yes or No Rican, etc.)		en of What Co USA 4. Race - Ame Black, Whit	ncan Indian,
Maryland 21215-0036	hin 72 hours aft e. an "natural", or Medical Exami	Completed by F	1 Nover Married 2 Marrie 3 Widowed 4 Divorced  15. Decedent' (Specify only highest	If Yes, Give Year or Date	s:	16a. Deced	1 ☐ Yes 25 dent's Usual ( kind of work DO NOT use	Occupat	Specify: ion uring most	of working	ng		Specify: W	hite Industry
/land 21;		To Be Com	12 17. Father's Name (First, Middle, L Peter Jerome	5 ast)		hea1t	h plan				(First, Middle,	Maiden S	non pro Surname)	ofit
e, Mary	1 and 2 sho Health and P am 27 is ma thar trauma		19a. Informant's Name/Relationsh John McGovern 20a. Method of Disposition		20b. F		Box 8	882		antow	Route Numbern, MD	2087		
altimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev ones.		1 ☐ Burial 2 ☐ Cremation 4 ☑ Donation 5 ☐ Other (Sp  21. Signature of Funeral Service L	ecity)	ate C	emetery, crer	natory or othe	Address	of Facility		655 W.			
			23a. Parl 1. Enter the disease, or o shock, or heart failure. List o	complications that cause	sed the deat	h. Do not ent	altimon er the mode o	ce, of dying,	MĎ such as	21201 cardiac oi	respiratory ar		cimore	Approximate Interval Between Onset and Death
8760,	Physician /Medical Examiner phusician and phusician and phusician and the prival-transit	ledicai Examiner	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or	as a consequence as a c	uence of):	Pardi	ome	уорс	The	7		3	
P.O. Box 6	that the death certifica hed by the attending ph detached for use as th	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnan 9 ☐ Unknown	n 2 ∏ Feta tat time of d	ideath 3□	Ectopic preg Other <i>(spec</i>					23	3d. Date of del Month	ivery Day Year
Division of Vital Records, P	law requires as been sigr 2 should be	Completed by Ph	Part II. Other significant condition	s contributing to deat	h but not res	ulting in the u	nderlying cau	se giver	n in Part I.		1 🗆 Y 24a. Was autop perfor	′es 2□ an	No 3 Proceed Proceedings Proceedings Procedure 24b. Were au prior to death?	othe cause of death?  obably 4 Nnknown  topsy findings available completion of cause of
Vita	rsician: s certific lirector,	To Be (	25. Was case referred to medical examiner?	Hospital: 1 Nnp	atient 2	ER/Outpatier	at 3 DOA	Other			(Check only o		Other (Sne	cift/)
sion of	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director; After this certificate his completely filled in by the funeral director, page	Certification; T	27. Manner of Death  1. Natural 2 Accident investig. 3 Suicide 6 Could n	28a. Date of I (Month, ation	njury Day Year)	28b. Time of Injury	M 280			No 2	8d. Describe h	iow injury	occurred	
<u>N</u>	ital or Attencers after death al Diractor;	Certifi	4 Homicide determine	289. Place of	Injury - At hi , etc. (Specif	ome, farm, str	eet, factory, c	office		2	Br. Location (S City or Tow	street and vn, State)	Number or Ru	ıral Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical		Physician: To the be xaminer: On the basi and manner	a of avamica	tion and/or in	residentian in		ومندات منجلت	h	of one also a sisses		alama amalaha	A = A fe = ( - )
	To the H within 24 To the F complete	M	29b. Signature and title of certifier	and			29c. L	icense	number 306	541		29d. Date	signed (Monti	to the cause(s)  th. Day, Year)  4 2005  5   Coud 21221
			30. Name and address of person of Rameh Sabafi	the completed cause of the 20/~	of death (Item	n 23a) (Турв. ВСК	Print) Perer	we	cle i	Rogo	1 Bal	hno	e Mai	s land 21221
	Sta Registi		31. Date filed (Month, Day, Year) NOV 2 3	2005 32 Reg	istrar's Signa	ture of the state	ade							

Amend item#9, perFH, G349 11-29-05 TT Department of Health and Mental Hygiene State Regist Amend Itrm #18 Per FH G850 12 102 1/62 1/64 OF Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Charles R. November 19 Muskauski 2005 8:30 p M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Gilchrist Center for Hospice Care Towson Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day) JUN 29 Birthplace (State or Foreign Country) **Funeral** 1**X**M 2□ F 53 170-44-4070 Director Usual Residence of Decedent 30.61.11 with the Maryland 10a. State 10b. County 10c. City, Town or Location Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event. It e Medical Examinar must be notified at 10d. Inside City Limits Director MD 1 ☐ Yes 2X No Baltimore Rosedale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 910 Rosedale Avenue 21237 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No þ 3 ☐ Widowed 4 ☐ Divorced USKAUSKI CHARLE white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Executive Director Penal System 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental I John Muskauski Seedar Sedar Julie ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Broadus-Muskauski-wife 910 Rosedale Avenue, Rosedale, MD 21237 f Health 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1 Department of I-Important: If Ite any injury or ot 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Chesapeake Crematory Inc. 11/22/2005 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) CAFA, Stephen D. Lohrmann, PA 8717 Green Pastures Drive, Towson, MD 21. Signature of Funeral Service Licensee M00986 21286 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Cirrhosis disease or condition resulting in death) yours /Medical Due to (or as a consequence of): Examiner years abvo alcohol Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine burial-transit attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) 68760 Physician/Medical the Box 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Day 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No P.O. 9 Unknown 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 Yes 1 ☐ Yes 2 ☐ No 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Dother (Specify) Nospila 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after deat To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2830 November 20 2001 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6601 N. Agron charles ino Charles DUSON 31. Date filed (Month, Day, Year) Registrar's Signature 32. State Registrar 2005

				• •	Maryland / Dep			•	_	
				For State Of I		ertificate of			2005	37828
				Hagistrar  1. Decedent's Name (First, Middle, Last)		Timoate of		Reg. F 2. Date of Death	16. W V V	3. Time of Death
		Physicia		Avis Wilburn Morrison				NOU 20	Year Year	722 PM
		/Medic Examin		4a. Facility Name (If not institution, give street and numb	er)	4b. City, Town, o	or Location of Death		c. County of Death	
				Upper Chesapeake Medical	Center	Bel A			Harford	
		Funeral		157 M 2□ F	Age (In yrs. last birthday Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea	r) 9. Birthp Cour	place (State or Foreign ntry)
Q		Director		213-38-5460 Usual Residence of Decedent	65		<u> </u>	ug. 29, 1	940 West	Virginia
20		yland yland		10a. State 10b. County	10c. City, Town or L	ocation			1	0d. Inside City Limits
-		a-fsh	ctor	WV Greenbriar	Neola					1 ☐ Yes 2 🔀 No
		death with the Maryland ms 23a or 28a-f show rmust be notified at	Director	10e. Street and Number		10f. Zip Code		10g. (	Citizen of What Cour	ntry?
\$V	)	s 23a		HC 70 N-19		2498		* 11	USA	
30			Funeral	11. Marital Status  1 □ Never Married  1 □ Never Married  1 □ Never Married  1 □ Yes 2	int Ever in U.S. 13. ps? of No	If Yes, specify Cub	lispanic Origin? (Spec an, Mexican, Puerto F	ican, etc.)	14. Race - Americ Black, White,	
20	036	ours after death with the Marylan ral', or Items 23a or 28a-f show Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ If Yes, Give 1 ☐ Year or Date	s:	1 ☐ Yes 2 ☑ No	Specify:		Specify: Wh	ite
3-	2-0		Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deci	edent's Usual Occup	nation during most of working d)	16b.	Kind of Business/In	
S	12	C * G#	пр	Elementary/Secondary (0-12) College (1-4	2r 5+)		d)		O- 0 -	
AVIS	d 21	filed v Hygie other t		8 17. Father's Name (First, Middle, Last)	Truc	k Driver	18. Mother's Name		ndependen en Sumame)	t
-	an	be be od o	To Be	Lester (nmn) Morrison			Nora (unl		,	
3	Maryland	d 2 should be filed within the and Mental Hygiene. 7 Is marked other then traumatic event, the M	-	19a. Informant's Name/Relationship (Type, Print)	19b. Mail	ling Address (Street	and Number or Rural		or Town, State, Zip	Code)
18				Jessie Morrison / Wife			Neola, WV	24986		
MOCRISON	Baltimore,			20a. Method of Disposition 1X Burial 2 □ Cremation 3 □ Removal from Sta	20b. Place of Disp cemetery, cre	osition (Name of ematory or other plac	Da (1)		Location - City or To	own, State
MC	Ē	Pa ant:		' 4 ☐ Donation 5 ☐ Other (Specify)	Welcome	Home Free		Be.	Air, Ma	cyland
	Bal	permit. Departr Importa any inju		21. Signature of Funeral Service Licensee	2	McComas F	ss of Facility Uneral Hon	ne, P.A.		
				23a. Part 1. Enter the disease, or complications that cau.	sed the death. Do not en	1317 Coke	sbury Road	d, Abingdo	on, Maryla	Approximate
				23a. Part1. Enter the disease, or complications that caushock, or heart failure. List only one cause on each Immediate Cause (Final	i line.	40	0	0,1		Interval Between Onset and Death
		Pnysician /Medical		disease or condition resulting in death)	as a consequence of):	cara	w voser	av W	Rene.	
		Examiner								
		p #	iner	Sequentially list conditions and the cause. Enter Underlying Cause (Disease or injury that initiated events c.	as a consequence of):			1827		
		ecute and -trans	Examiner	Cause (Disease or injury that initiated events c						
20	760,	ate be executed nysician and he burlal-transit	cal E	Due to (or	as a consequence of);					
9	687	ficate phys s the		d	A CVI VALVE A CVI					
	XO	leath certificat attending phy I for use as th	Physiclan/Med	IF FEMALE: 23c. If yes, outcomes 23c. If yes					23d. Date of delive	ery
#	Ω.	death e atte	icla	in the past 12 months?	at time of death 5	□Ect <i>o</i> pic pregnancy □ Other <i>(specify)</i> _	<i>'</i>		Month	Day Year
· ·	P.0	at the de by the a stached	hys	9 Unknown	1					_
#	S,	The law requires that the death certifica te has been signed by the attending ph page 2 should be detached for use as th	by	Part II. Other significant conditions contributing to deat	n but not resulting in the	underlying cause giv	en in Part I.		use contribute to the	
	ecord	w requir been si should	ompleted	il-le conficto	0		) <u> </u>	-		ably 4 □Unknown
	Rec	has by	шp	Hestery of EVA (Creve	+ asculor	v accord	ent)	24a. Was an autopsy performed?	24b. Were auto prior to cor death?	psy findings available npletion of cause of
3			e Co	25. Was case referred to medical	<i>L</i> ·		an Ri I Doub	1□ Yes 2√N		210 No
$\in$	Vital	Physiclan: this certific ral director,	0 0	examiner?  1 Keyes 2 No  Hospital: 1 Inp.	atient 2, ER/Outpatie	ent 3 DOA	er: 4 Nursing Hom		6 ☐ Other (Specify	41
-	o	ding Phy I. After thi funeral	T :u	27. Manner of Death 28a. Date of 1			y at 28	d. Describe how inj		,
S	ior		atlo	2 Accident investigation	say roal, injury		Yes 2 □No			
$\exists$	Division	I or Attendater deatl	ertification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of building,	Injury - At home, farm, st etc. (Specify)	treet, factory, office	28	f. Location (Street a City or Town, Sta	and Number or Rura te)	l Route Number,
7		pital ours aral	O	29a. Certifier 1☐ Certifying Physician: To the be	at at my kenyiladan dan	th assumed at the fire				<u> </u>
MOTISM		To the Hospital or within 24 hours afte To the Funeral Director completely filled in the Funeral Director of the Funeral Direc	edical	29a. Certifier  (Check only one)  1 Certifying Physician: To the beside and manner on the basis and manner	of examination and/or in	nvestigation, in my o	ne, date and place, an pinion, death occurred	d due to the cause( I at the time, date a	s) and manner as st nd place, and due to	ated. the cause(s)
W. 12		To the Hos within 24 ho To the Fun completely i	Me	29b. Signature and title of certifies	1 1112	29c. Licens	e number	29d. D	ate signed (Month,	Day, Year)
		1		Benard & YMan MI	DIKE	100/4	F206	Abl	EMBFR 7	2005°
	1	7		30. Name and address of person who completed cause	death (Item 23a) (Type	Print) 1/2/2	Dias A.	E Day	a) 11/ >	7
	9			BEKNYKD'J. YUNNY	strar's Signature	16, TULA	BIRD AVA	- ISALT	1, Md 21	マスム
		Sta Registr		31. Date filed (Month, Day, Year) 2005	strar's Signature	В				

MORRISON, AVIS WILL BURN

# 447087

		For State Registrar	State of Marylan	d / Depa		ealth and N	Mental Hyg		37829
Physic /Med Exam	ical	1. Decedent's Name (First, Middle, Last  James Snyder  4a. Facility Name (If not institution, give	Maus street and number)	el	Cher	Location of Death		Day Year beric Zoo	secges
Funera Directo		5. Social Security Number 6/Security Number 492 56 4142 X 12  Usual Residence of Decedent	TM 2015	5 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day Oct 29,		thplece (State or Foreign ountry) ahoma
ne Maryland 8a-f show	Director	10a. State 10b. County  Maryland Charles	10c. Cit	y, Town or Lo Wa	aldorf 10f. Zip Code			10g. Citizen of What Co	10d. Inside City Limits 1  Yes 2 No
Baltimore, Maryland 21213-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iteme 23a or 28a-f show any injury or other treumatic event, the Medical Examination and the notified at	Funeral Dir	10e. Street and Number 2175 Kay I	Hill Drive  12. Was Decedent Ever in U. Armed Forces?	.S. 13.	Was Decedent of Hi	20601 ispanic Origin? (Span, Mexican, Puert		United St	ates encan Indian,
0036 hours after tural, or ite	d by Fur	1 Never Married 2 Married 3 Widowed 4 Divorced	vt (∑Yes 2 ☐ No 4H/Yes, Give Year or Dates:		1 Yes 2 TAN	Specify:		Specify:	White
Maryland 21215-0036 d 2 should be filed within 72 hours af th and Mental Hygiene. 27 is marked other than "natural", or treumatic event, the Medical Experi	Be Completed	15. Decedent's Ed (Specify only highest grant Elementary/Secondary (0-12)	Callege (1-4ar 5+)	(Give	kind of work done of DO NOT use retired iputer Spe	during most of wor () ecialist		Census Bu	
yland tould be file I Mentat Hy varked other	To Be (	17. Father's Name (First, Middle, Last) James Maus	Time (Print)	10h Maiti	na Addross (Street	Shirley	Feil	Maiden Sumame) or, City or Town, State,	Zin Gode)
re, Mar tand 2 sh Health and tem 27 is m		19a. Informant's Name/Relationship (7) Diana Maus (wife) 20a. Method of Disposition	20b. F	2175	Kay Hill  osition (Name of matory or other place)	Drive,			
altimore, mit. Pages 1 ar partment of Hea portant: If item	ģ	1 ☐ Burial 2 ⚠ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen	Pemoval from State Le	e Crem	atory Nov	18, 200	5 Funeral	Clinton, Home,Inc	
m gaes		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	Dications that caused the deat one cause on each line.	h. Do not en	Alexandri ter the mode of dyin	a Ferry ig, such as cardiac	Rd, Clii or respiratory an	nton, MD 2 rest.	0735 Approximate
Physician /Medica Examine	l r	Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a consect	querice or).	e Accid	dent w	ih Co	morecet	1 month
68760, clificate be executed g physician and as the burial-transit	dical Examiner	S-que ritally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C. Due to (or as a consect Due to (or as a consect d.						
Box death cert e attending of for use	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fete 4 ☐ Pregnant at time of of 9 ☐ Unknown	el death 3	□Ectopic pregnancy □ Other (specify) _	1		23d. Date of de Month	olivery Day Year
ecords, P.O law requires that the as been signed by th 2 should be detach	þ	Part II. Other significant conditions of	ontributing to death but not res	sulting in the	underlying cause giv	en in Part I.	23e. Did t	an 24b. Were a	Probably 4 Unknown
I Re The la ate has page 2	e Completed	25. Was case referred to medical				26. Place of Dea	auto perfo 1 ☐ Yes	rmed? death? 2☑No 1☐Ye	s 2 No
ivision or Attending fler death. Director: Atte in by the fune	Certification: To B	examiner?  1 Pes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not b 4 Homicide determined	28a. Date of Injury (Month, Day Year)	28b. Time Injury	Word 1□	y at k? Yes 2 No	28d. Describe 28f. Location ( City or To	dence 6 Other (Sphown injury occurred )  Street and Number or Fun, State) Holly	roed off
Divi To the Hospitel or At within 24 hours after of To the Funeral Direct completely filled in by	Medical C	29a. Certifier 1 ☐ Certifying Ph (Check only ) 2 Medical Example 1 ☐ Certifying Ph (Check only ) 29b. Signature and title of certifier	nysician: To the best of my kn niner: On the basis of examin and marr in stated	owledge, dea ation and/or i	ath occurred at the finnestigation, in my control 29c. Licens	opinion, death occu	e, and due to the urred at the time,	cause(s) and manner a date and place, and du 29d. Date signed (Mor	ue to the cause(s)/
7.C		30. Name and address of person who	completed cause of death (Ite	) m 23a) (Type	Ate	205382	-7	Novemb	18 2005
	State	3001 Hospital 31. Date filed (Month, Day, Year)	32. Registar's Sign	aserl	y kest	ry land			
DHMH 17 Rev	strar 1/2001	110 / 2 3	2005 Been	ORIGII	MAL NAL				28007

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydienes O. O. Programment of Health and Hydienes O. O. Programment of Health and Hydienes O. O. Programment of Health and Hydienes O. O. Programment of Health and Hydienes O. O. Programment of Health and Hydienes O. O. Programment of Health and Hydienes O. O. Programment of Health and Hydienes O. O. Programment of Health Andread O. O. Programment of Health Andread O. O. Programment of Health Andread O. Programment of Health

		•	For State Registrar	State of M	arylanu / L	Certific	cate of l	Death	ientai ny	Reg. No.	- 400	37830
	Disconini		1. Decedent's Name (First, Middle, La		\				2. Date of D Month			3. Time of Death
	Physici /Medic		FINDA	C. K	ACCRA	7			11	るる		4:20 AM
	Examin		4a. Facility Name (If not institution, giv			4b.	City, Town, or	Location of Death		4c.	County of Death	)
	ĸ		7232 Patton Driv				Woodbi				Carroll	
١.	Funeral Director			□M 2□E	ge (In yrs. last bin		Inder 1 Year nths Days	If Under 24 Hrs. Hours Min.	8. Date of B (Month, D Jan 2.7	irth <i>ay, Year)</i> 7 <b>,</b> 19	9. Birth Cou	place (State or Foreign untry) Y
	death with the Maryland ms 23a or 28a-f show Internal be notified at	_	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location	n	· · · · -				10d. Inside City Limits
	Ba-f s	cto	MD Carrol	1		Woodl	bine					1 ☐ Yes 2 ☐ No
	or 2	Dire	10e. Street and Number			10	of. Zip Code	_		10g. Citi	zen of What Cou	intry?
	s 23s	ral	7232 Patton Driv		5		2179				USA	. —
920	after or Ita	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Tyes 2V If Yes, Give Year or Dates:	?		Decedent of Hi , specify Cuba (es 2)() No	ispanic Origin? (Spin, Mexican, Puerto Specify:	ecify Yes or N Rican, etc.)	0-	14. Race - Amer Black, White Specify: Wh	
Maryland 21215-0036	72 ho natur	Completed	15. Decedent's E (Specify only highest gra	de completed)		Decedent's (Give kind of life, DO N	Usual Occupa of work done of OT use retired	ation during most of work	ing	16b. Ki	nd of Business/l	ndustry
212	iene iene r than "r	шо	Elementary/Secondary (0-12)	College (1-4or				cretary		C16	erical	
b	e filed I Hyg othe	BeC	17. Father's Name (First, Middle, Last,		, , ,			18. Mother's Name	First, Middle			
lar	uld be dental rkad c fic ave	To B	Leonard Rice					Eva	Me1to	n		
lar)	es 1 and 2 should bot Health and Ment I tam 27 is markac r other traumatic a		19a. Informant's Name/Relationship (					and Number or Rura				ip Code)
	and sealth m 27		Mr. Glenn E. McCr	ay, Jr. (S	Spouse)	7232 I	Patton,	Dr.,Wood				
Baltimore,	ges 1 t of H if Ital		20a. Method of Disposition  V Burial 2 Cremation 3	Removal from State			(Name of y or other place		Date	20c. Lo	cation - City or T	own, State
ti m	tmen tant:		* 4 ☐ Donation 5 ☐ Other (Specif	′)	Lake '			rk 11/28			esville,	
Bal	permit. Pages. Department of H Important: If Its any injury or of		21. Signature of Funeçal Service Licer	Hude	L	HATC Syke	meand Address HT FUN Sville	ERAL HOME , MD 2178	E & CHA 34 (410	PEL )-795	PA (Box 5-1400	: 195)
п			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that cause one cause on each li	d the death. Do r	not enter the	mode of dyin	g, such as cardiac	or respiratory	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition					StageTV				Onset and Death
	/Medical Examiner		resulting in death)	4.	a consequence							
	Ladilliter	-	Sequentially list conditions,	b. — Due to (or as	a consequence	of):					-	
ĹĴ	ted	nlne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequence	Ji).						
4	be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	C. Due to (or as	a consequence	of):						
68760,	e be sicia e buri	call	· ·	d								
	tificate ng physi as the	ledical										
O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physiclan/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal death		pic pregnancy er (specify)			2	23d. Date of deliv Month	very Day Year
P.O.	that t	y Ph	Part II. Other significant conditions of	ontributing to death b	out not resulting in	the underly	ing cause give	en in Part I.	23e. Did	tobacco u	se contribute to	the cause of death?
rds	quires n sign ald be	d by	Liver Failor	e, En	cephal	10 Pat	1-1		10	Yes 2	No 3□ Pro	bably 4 Unknown
Ö	w requires been si	lete							24a. Wa	s an	24b. Were aut	opsy findings available
Vital Records,	The lav	Completed								ormed?	prior to co	empletion of cause of
ita	iclan: Th certificate rector, pag	Be C	25. Was case referred to medical					26. Place of Death	1 Yes	2 No	1 ☐ Yes	2   NO
f V	dis di	To E	examiner? 1 Yes 2 No	Hospital: 1 Inpatio	ent 2 ER/Ou	tpatient 3[	DOA Othe	er: 4 🗆 Nursing Ho	me 5 Res	idence 6	6 □Other (Speci	rfy)
0 0	fter fter	on:	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Inju (Month, Da	ury 28b. 7	ime of	28c. Injury Work	at k?	28d. Describe	how injury	y occurred	
sio	tandi leath. tor: A the fu	catl	2 Accident investigation 3 Suicide 6 Could not b			M		Yes 2 □No				
Division of	of or Attandi after death. Director: A d in by the fu	Certification:	4 Homicide determined	286. Place of in	jury - At home, fa tc. (Specify)	rm, street, fa	actory, office		281. Location City or To	(Street and own, State)	d Number or Rur )	al Route Number,
	To the Hospital or Attanding within 24 hours after death. To tha Funaral Director: After completely filled in by the funer	Medical C	29a. Certifier (Check only one)	ysician: To the best niner: On the basis of and manner st	of examination and	, death occu	urred at the time ation, in my op	ne, date and place, pinion, death occurr	and due to the	cause(s) , date and	and manner as splace, and due to	stated. to the cause(s)
	omple	Me	29b. Signature and title of certifier	A			29c. License	e number		29d. Date	e signed (Month,	Day, Year)
	~ > = 0		Don X. M	I har			03	0573		71-	22-05	
	0,		30. Name and address of person who	completed cause of o	death (Item 23a) (	Type, Print)						
	\ 		Jon K. Minford.	M.D. 110	065 Li	HILE T	aturer	rt PKWY.	Colur	nba	MD	21044
	Sta Registr		31. Date filed (Month, Day, Year) NOV 2 3 20	32 Registr	rar's Signature	Soul	20					

				1 - For State Registrar		State of	f Marylai		artmer			nd Me	ental Hy	giene Reg. No.,	0 0			
		79		Decedent's Name (First	st, Middle, Last	1)						2	Date of De	ath 6	201	35	3. Time	of Death
		Physicia /Medic Examin	al	Richard S. 4a. Facility Name (If not it			nber)		4b. City	, Town, or	r Location of	Death	Month 11	17 4c.		Year 2005 of Death	3:	35 A
				Suburban Ho	ospital				Bet	hesd	а			Mo	ntgo	mers	7	
		Funeral		5. Social Security Number	er 6. Se	×	7. Age (In yrs	,	) If Unde	r 1 Year Days		4 Hrs. 8	3. Date of Bir (Month, Da 1-15-	th		9. Birthp	ace (State	or Foreign
	報查	Director		218-30-1245		XM 2□F	73	Yrs.	WOITIN	Days	riodis		1-15-	1932		Virg	inia	
		Pu &		Usual Residence of Dece 10a. State 10b.	edent	_	10c C	ity, Town or L	ocation		<del></del>					1	nd Inside	City Limits
		eho eho	2		ontgome	2017		vy Cha								1.		s 2 No
		with the Maryland e or 28e-f ehow be notified at	Director	10e. Street and Number	Jiicgome	Ly	One	vy Gila		p Code				10g. Citiz	an of Wi	hat Caus		
		with											ĺ			nat Coun	uy r	
		ne 23	Funeral	8700 Jones 11. Marital Status	Mill R	oad 12. Was Dece	dent Ever in l	J.S. 13.		815 Ident of H	lispanic Origi	in? (Speci	tv Yes or No	US - 1		- Americ	an Indian,	
	10	fler of the series	Fun	1 Never Married	2 Married	Armed For	2 🔀 No				lispanic Origi an, Mexican,	Puerto Ri	can, etc.)			, White,		
	030	ours af	by	3 Widowed 4 🗆	Divorced	If Yes, Giv Year or Da	e ates:		1 🗆 Yes	2 No	Specify:				Specify:	Whit	.e	
	21215-0036	72 hc	Completed	15. U (Specify on	Decedent's Edu	ucation de completed)	-	16a. Dece	edent's Usu	al Occup	ation during most	of working	7	16b. Kir	nd of Bus	iness/Inc	lustry	
	2	ithin	npi	Elementary/Secondary		College (1	-4or 5+)				during most ( d)			_				_
	2	led w lygier her th		12 Settled Name (Size)	Adiabata ( and)	4		Appr	aiser		10 11-15-1	1- N (	Cina Adiddo				leal 1	Estate
	and	be fi	Be	17. Father's Name (First,									First, Middle		<i>Sum</i> ame	"		
	Ž	should be filed within 72 hours after deeth with the Maryland nd Mental Hyglene. In marked other then "neturel", or teme 23e or 28e-f ehow marke other then "neturel", or teme 23e or 28e-f ehow marke event, the Mudical Exaciling Lines to incitified at	ဥ	Chauncey Ro	0			10b Mail	ling Address	o (Ctroot	Clara and Number		1 Hill		Tour C	itata Zin	Cadal	
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		T T T T T T T T T T T T T T T T T T T		20a. Method of Disposition	<u>.</u>	CCI	20b.	Place of Disc	osition (Na	me of	1	Da					wn, State	
	Baltimore,			1 ☐ Burial 2 🛱 ore 4 ☐ Donation 5 ☐	emation 3 🗆 F	Removal from	State	cemetery, cre	•		· 1	1 10	2005	D - 1.		1.	MD	
کے	Ė	# # # # # # # # # # # # # # # # # # #		21. Signature of Funeral			Cn	esapea	2. Name a	nd Addre	ss of Facility							
£	B	Dep impo		W /	22		01358	R	app F	uner	al & C	Silv	er Spi	ing Servi	MD 2 ces	0910 933	Gist	Ave.
SAM				23a. Part1. Enter the dis	sease, or compl	lications that ca	aused the dea										Approxim Interval B	
3		Physician		Immediate Cause (Final		Seps										8	Onset and days	d Death
m		/Medical		disease or condition resulting in death)		a	or as a conse	quence of):									day	
Ö		Examiner		Carrentially list anaditio		<sub>b.</sub> Atri	al Fib	rillat	ion							У	ears	
		D =	ner	Sequentially list condition any, leading to immedicause. Enter Underlying Cause (Disease or injury	iate		of at a conte	quanea of):										
20	job	ite be executed sysicien and ne burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last		C.	ration		onia							8	days	3
_	,092	De execien a		resulting in dealin) Last		Due to (	or as a conse	quence of):										
	~	5 × 5	dical			d												
_	39 X	death certifical e ettending phy id for use as th	Completed by Physician/Med	IF FEMALE:		23c. If yes, out	come of predic	ancy										
_	Bo	eath c	cian	23b. Was decedent preg in the past 12 mont	grianit	1 Live b	irth 2 ☐ Fet ant at time of	al death 3	□Ectopic p		1			2	3d. Date Mont		ry Day	Year
_	Ö	0 0 0	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		9□ Unkno		304(1)	_ Cirior (3	pochy)		Timora						
2	0	law requires that the es been signed by th 2 should be detache	y P	Part II. Other significant	conditions co	ntributing to de	ath but not re	sulting in the	underlying	cause giv	en in Part I.		23e. Did 1	obacco us	se contrib	oute to th	e cause of	death?
lurra	Records,	quires n sign uld be	Q De	Myelodyspla	astic								10	Yes 2	]No 3	B 🗌 Prob	ably 4 5	Unknown
7	0	s been si should	jet										24a. Was		24b. W	ere autop	sy finding	s available
ユ		o = 2	E								<u>-</u>			ormed?	pr de	or to con ath?	npletion of	cause of
5	Vital	iician: The l certificate he rector, page	0	25. Was case referred to	medical	30=					26. Place of	of Death /	1 □ Yes Check only		11	Yes	2 LI 190	
		Physicia this cert al direct	To B	examiner? 1 ☐ Yes 2 ☐ No	ŀ	Hospital: 1 v l	npatient 2	☐ ER/Outpatie	ent 3 D	OA Oth	or.		5 ☐ Resi		Other	(Specify	.)	
7	n of	ding Ph h. After thi funeral		27. Manner of Death 1 XNatural 5	Pending	28a. Date of	of Injury h, Day Year)	28b. Time Injury	of	28c. Injun Wor			d. Describe					
5	Division	sndir eath. or: Al	Certification:	2 Accident	investigation				М		Yes 2 □ N	0						
ta	Ξ	or Att ter de irect	Ě	3 Suicide 6 L 4 Homicide	Could not be determined	286. Place	of Injury - At I	nome, farm, s	treet, factor	y, office		28	f. Location ( City or To	Street and wn, State)	Number	r or Rura	Route Nu	mber,
4	۵	pital or Attsnoors after deal ours after deal leral Director; filled in by the	ပိ	<u></u>								1/2						
RicHard		0 4 5 >	edical	29a. Certifier 1/2. (Check only 2	Certifying Phy Medical Exami	iner: On the ba	isis of examin	iowledge, dea ation and/or i	ith occurred nvestigation	d at the tin n, in my o	ne, date and pinion, death	place, an occurred	d due to the lat the time,	cause(s) date and	and man place, ar	ner as st nd due to	ated. the cause	(s)
A		To the Hos within 24 h To the Fur completely	Mec	29b. Signature and title of	of certifier	and manr	er stated.		29	c. Licens	e number			29d. Date	signed	(Month. I	Day, Year)	
		F≯≓8		· Va.	au/	K Co	0.			1960				11-1	_			
		0/		30. Name and address o		ompleted caus	e of death (Ite	m 23a) (Tvne										
		7		R. Tuli 108			•			hers	burg.	MD 2	0878					
	7	Sta	ite	31. Date filed (Month, Da			egistrar's Sign		- P P		0>							
		Registr	ar		- 0 000	r Ego		The state of the s	1									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State #1.28 Pegistrar Amend Item #1,468c810c PerPHY8FIF G150 1290 705 JH Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Marvin Linwood Oates. Day Year 1100 A M **Physician** November 13. 2005 Linwood Onton /Medical 4b. City. Town, or Location of Death Clearwater Beach Baltimore, Marylan 4a. Fecility Name (If not institution, give street and number) Anne Arundel Examiner 8133 High Point Rd. 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Months XXM 2 F North Carolina Yrs. Dec. 27, 1931 Director 218-26-3103 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, the Medical Examinar must be notified at Yes 2000 Clearwater Beach Director Boach MD Anne Arundel the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21226 8116 Edgewater Rd. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filled within 72 hours after c Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural, or item any injury or other traumatic svent, the Medical Exempers 1 Yes 2 No 1948 If Yes, Give 1951 Year or Dates: 1 ☐ Never Married 2⁄ Married white Baltimore, Maryland 21215-0036 1□Yes 2♥No Specify: White Specify þ 3 Widowed 4 Divorced 1954 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Food Industry Meat Cutter 9th 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First, Middle, Last) Be Mabel Rasberry 2 Willie L. Oates 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 8116 Edgewater Rd. Clear Water Beach, MD 21226 Marlene Oates- wife 20b. Place of Disposition (Name of 20c. Location - City or Town, Stete 20a. Method of Disposition Baltimore Crematory Loudon Park 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

1 ☐ Donation 5 ☐ Other (Specify) Nov. 15, 05 Baltimore City 22. Name and Address of Facility Loudon Park Funeral Home 21. Signatur Funeral Service Li ensee 3620 Wilkens Ave. Baltimore, MD 21229 23a. Part. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each Approximate Interval Between Onset and Death ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition Chimuchi **Physician** resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-tran and Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year ō in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown igned be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. Completed by Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 ☐ Yes 2 No page certificate Division of Vital or Attending Physician: director 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Injury at 28d. escribe how injury occurred examiner? Hospital: 1 ☐ Yes 2 No ٩ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: After Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after deati To the Funeral Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) by 4 Homicide To the Hospital filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 14/05 cause of death (Item 23a) (Type, Print) 8028 Ritchie Hwy sinte 134 Rasadera MD 21122 Karin M Dozu L MO

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

2005

**ORIGINAL** 

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State Amend Item #17 Per FH G849 11 (23) (5) at the Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Regional Prince Hospita Laure George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 8. Date of Birth Month, Day, 7. Age (In yrs. last birthday) Yrs. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1□M 2**X**F 053-16-2120 Director Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits or 28a-f ehov other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Completed by Funeral Director 10f. Zip Code 10g. Citizen of What Country? u z should be filed within 72 hours after deeth with the and Mental Hyglene. 20708 Was Decedent Ev. Armed Forces?
1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life\_DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) hnician Be William Washington Pages 1 and 2 should nent of Health and Men Address (Street and Number or Ru Department of Health a Important: if itam 27 is any injury or othar tra once. 7316 Doman 20a. Method of Disposition 20b. Place of Disposition (Name of Burial 2 Cremation 3 Removal from State 1 Burial 2 ☐ Cremation 3 ☐.

4 ☐ Donation 5 ☐ Other (Specify) 21. Service Lice 23a. Part1. End the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician /Medical resulting in death) Examiner Sequentially list conditions, Physician/Medical Examiner dany, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events attending physicien and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 □ Yes 2 ▼ No 4□Pregnant at time of death Month Day Year 5 Other (specify) 9 Unknown Š Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by page 2 should be 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform*e*d 1 ☐ Yes 1 🗌 Yes 2 No 3 No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check on one Other: 1 Yes 27 No Certification; To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death. To the Funerel Director: A 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the 29a. Certifier edical completely n the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number completed cause of death (Item 23a) (Type, Print) 30. Name and 4300 GALLAUTTOX L

DHMH 17 Rev 1/2001

Registrar

3 2005

			For State	State of Marylan		ment of H		d Mental H		/1115	37831.
			Registrar  1. Decedent's Name (First, Middle, Last)	)	Certi	ilcate of t	Dealii	2. Date of			3. Time of Death
	Physicia /Medic		John W	Planth	+101			Neuz	Mber	y Year 17 2005	2:25 AM
A	Examin	- 11	4a. Facility Name (If not institution, give			b. City, Town, or	Location of D			. County of Death	, ,
			7145 BALL MORE 5. Social Security Number 6. Se	ANNAPOLIS 1. Age (In yrs.	Blud.	FERN f Under 1 Year	DA E	Hrs. 8. Date of	Righ	NNE A	RUNDA!
	Funeral Director			20F 59		Months Days			Day, Year)	Coul	place (State or Foreign htry)
			Usual Residence of Decedent								
	arylar ehow	<u>_</u>	10a. State 10b. County		y, Town or Loca						1 ☐ Yes 2 ☐ No
	the M	Director	MD ANNE A  10e. Street and Number	RUNDER FE	RNDA	10f. Zip Code			10g. Cit	izen of What Cou	ntry?
	3a or	10		RE ANNAPOLIS	BLVD.		061			USA	
	death	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?				? (Specify Yes or uerto Rican, etc.)	No-	14. Race - Ameri Black, White,	
36	ours after death with the Marylan ral', or Itama 23a or 28a-f ehow Examiner must be incliffed at	by Fu	1 Never Married 2 Married	1 □ Yes 2 ☑ No If Yes, Give		Yes 2 No	Specify:				HITE
5-0036	within 72 hours after death with the Maryland ene. Inten "natural", or Itama 23a or 28a-f ehow he Micical Examiner must be ricitlised at	ed b	3 Widowed 4 Divorced  15. Decedent's Edu	Year or Dates:	16a. Deceder	ni's Usual Occup	ation		16b. K	ind of Business/In	
215	hin 72 ho s. nn "natur Medical	piet	(Specify only highest grad	le completed)  College (1-4or 5+)	life. DC	nd of work done o NOT use retired	d)	working	20		
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Maryland	should be filed within the Mantal Hygiene. Thanked other than matic avant, the Mantal than than than than than than than than	Be	17. Father's Name (First, Middle, Last)	01	115	7/-	18. Mother's	Name (First, Mic			1011
2	should and Men a marke umatic	2	EDMOND  19a. Informant's Name/Relationship (T)		19b. Mailing		and Number o	r Rural Route Nu		IL HOLL or Town, State, Zij	Code)
Σ	and 2 sauth er n 27 la		DONNA PLANTHOL	T, WIFE				NNAPOU		FERI	21061
ore,	ges 1 au t of Hea if Item or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ I	20b. F	Place of Disposit cemetery, crema	on (Name of		Date		ocation - City or T	
Ĕ	Pages ment of I ant: If Its lury or o		4 Donation 5 Other (Specify,			LLEY CE				10NIUM	
Baltimore,	permit. Pages 1 and 2 should Depertment of Health end Men Important: If Item 27 la marke any injury or other traumatic <u>once.</u>		21. Signature of Funeral Service Licens	).	1 3 4		ss of Facility				VICE P.A-
_	10144		23a Part 1. Enter the disease, or comp	lications that caused the deat	h. Do not enler		HIE H		LTO.	MD 2	Approximate
	Physician		shock, or heart failure. List only of Immediate Cause (Final	ne cause on each line.	01.	lette	leon.	1 (01)	Cali	, m	Interval Between Onset and Death
1	/Medical		disease or condition resulting in death)	a. Due to (or as a conseq	juence of):	wry !		(41)	CUPUI	7	140:11.03
Н	Examiner	_	Sequentially list conditions, if any, leading to immediate	b	KY	on as	ey	( gr	1100	$\sim$	1024rs
J	bed nsft	nine	Cause (Disease or injury	Due to (or as a conseq	juence or):						/
, V	execut n and ial-tra	Examiner	that initiated events resulting in death) Last	c Due to (or as a consec	ruence of):						
8760	cate be executed bhysicien and the burial-transit	ical		d							
Õ	ing ph	Med	IF FEMALE:							1	
Вох	death certific e attending pl d for use as t	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregn: 1☐Live birth 2☐Feta 4☐Pregnant at time of c	il death 3 E	ctopic pregnancy	у			23d. Date of deliv Month	ery Day Year
P.0.	che th	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	J-04.11 5 - 1	titol (specify)			_		
	₽ B B	by PI	Part II. Other significant conditions co	ontributing to death but not res	sulting in the und	ertying cause giv	ven in Part I.	23e. [	oid tobacco	use contribute to	the cause of death?
Records,	law requires es been sign 2 should be							1	☐ Yes 2	Mo 3□Pro	bably 4 Unknown
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<u>ه</u>	T ele	Con						1 🗆 Y	erformed? es 20 No	death?	2000
of Vital	Physician: T this certificat rel director, pa	Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	] ER/Outpatient	all post Oth		Death (Check of		C Dother (Cons	4.1
of		n: To	27. Magner of Death	28a, Date of Injury	28b. Time of	3 DOA 28c. Injur	4 🔲 Nursi			6 ☐Other (Speci iry occurred	ry)
ion	Attending F r death. actor: After by the funer	atio	Natural 5 Pending 2 Accident investigation		Injury		Yes 2 □No				
Division	or Atta	Certification	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci		t, factory, office			on (Street a Town, Stat	nd Number or Rur e)	al Route Number,
Ω	To the Hospital or Attano within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Ph	ysician: To the best of my kn	owledge death of	occurred at the tir	me date and r	place, and due to	the cause(s	and manner as	stated
	e Hos 24 hc a Fun letely	Medical		nines: On the basis of examination and manner stated.							
	To th Withir To th	ž	29b. Signature and title of contilier	N	7	29c. Licens	se pumber	<del>-</del> KJ	29d. Da	ate signed (Month,	Day, Year)
				2 ()//		7	0115	J 7	No	Verber	-17,2005
	10		30. Name and address of person who	completed cause of death (Ite	23a) (Type, P	In Later	Tive,	Went.	Mas	Ast.	7106/
4	St	ate	31. Date filed (Month, Day, Year)	32. Pagistrar's Sign	ature	10/ 10	)	21000	, ,,	1 201	
	Regist		NOV 2 3 26	005	He Con	rett 1					

Willie Lee Powelī Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 05-07183 State of Maryland / Department of Health and Mental Hygiene N.IM Certificate of Death Rag. No 2. Date of Death Decedent's Name (First, Middle, Last) Day Year **Physician** Willie Lee Powell 2.4 2005 0015 October /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Prince George's Hospital Center Cheverly Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number unk 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 ₹ M 2 □ F Vrc 1943 Washington DC Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location ehow. 10d. Inside City Limits 1 ☐ Yes 2√ No Director Prince George's Forestville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20747 2722 Lorring Drive #303 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after Hygiene. 1 Yes 2 No
If Yes, Give
Year or Dates: 1X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) housekeeping private businesses unk unk permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: if Item 27 is marked other any Injury or other treumatic event, once. unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Tracey Harris/niece 2722 Lorring Drive #303 Forestville, MD 20747 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 □Donation 5 ♥Other (Specify) in state 21. Signature Fruneral Service Licensee 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street altimore, MD 21201 Ronald S. 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) emplications of Head Injuries **Physician** /Medical Due to (or as a consequence of) **Examiner** Esquentially liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical îhe IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetaf death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Į Month Year 4☐Pregnant at time of death 5 Other (specify) P.0. the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 1 Yes 2□No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 fnpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred Certification: 1 Natural
2 Accident Passenger in a motor 8:04 AM 10/17/05 collision investigation Velucie 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Aural Aoute Number, City or Town, State) Pennsy Wanta TVE 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide

To the Mospitel or Attending I within 24 hours after death. To the Funerel Director: After

29b. Signature and title of certifier la mo

and manner stated.

29c. License number OCME

2X Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Dey, Year)

October, 24, 2005

Forestville Rd Forestville MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street Baltimore, Maryland 21201

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

Medical

29a. Certifier

(Check only one)

31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

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		I.	1 - For State Registrar	State of M		d / Dep		t of H	lealth a	and M	ental Hyg	_	0.5	370	336
			Decedent's Name (First, Middle,	Last)							2. Date of Dea	ath	00	3. Time of	Death O
	Physici		Cleopatra E. P	etroff							Month NOVEMBE	R 1, 20	Year 05	10:35	5 A M
	/Medic Examin		4a. Facility Name (If not institution, g				4b. City,	Town, or	Location o			4c. County		10.0	
	LAGIIIII	C	603 SLIGO AVE	APT 503			SIL	ÆR	SPRIN	G		MONTG	OMERY	CO	
	Funeral		5. Social Security Number unk 6	. Sex 7. Ag	ge (In yrs.	last birthday			If Under		8. Date of Birti (Month, Day			place (State o	r Foreign
, i	Director			1□M 2√F	86	Yrs.	Months	Days	riours	IVIII I.	Oct 2,	1919	000,		unk
	D.		Usual Residence of Decedent		100 Ci	ty. Town or L	costico							0d. Inside Ci	its Limito
	arylar show	_	10a. State 10b. County										'	1 🗆 Yes	
	8a-f	cto	MD Montgo	mery	Si	lver S						10 000			-X-
	or 2	Die	10e. Street and Number	#502			10f. Zip		910			10g. Citizen of USA	What Cour	ntry ?	
	within 72 hours after death with the Maryland ane. then "natural", or items 23e or 28e-f show the Madical Examiner must be notilied at	Funeral Director	603 Sligo Avenu	K 12. Was Decedent	Funcin II		Was Desa			aia2 /6aa	of Vac as No		ce - Americ	an Indian	
	er de litem	nue		Armed Forces	,	unk	If Yes, spec	ofy Cuba	ın, Mexican	n, Puerto I	cify Yes or No- Rican, etc.)	Bla	ck, White,		
36	rs aft	Ž	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	NO	anne	1 ☐ Yes	2× No	Specify:			Specif	y: wh	ite	
21215-0036	hou	Completed by	15. Decedent's			16a. Deci	edent's Usua	al Occup	ation		unk	16b. Kind of B	usiness/In	dustry	unk
5	n n	plet	(Specify only highest	grade completed)	E.)	(Giv	DO NOT us	rk done i se retired	during mos. d)	t of workir	ng Gille				0.1110
12	the iene	E o	Elementary/Secondary (0-12) unk	College (1-4or	D+)										
D	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. is marked other then "natural", or items 23a or 28a-f show aurmatic event, the Mudical Examiner must be notified at	BeC	17. Father's Name (First, Middle, La				1	unk	18. Mothe	er's Name	(First, Middle,	Maiden Sumar	ne)		unk
an	Mental arked o	To B													
Maryland	ges 1 and 2 should t of Health and Men if item 27 is marke or other traumatic	-	19a. Informant's Name/Relationship	(Type, Print)		19b. Mai	ing Address	(Street	and Numbe	er or Rura	l Route Numbe	r, City or Town	, State, Zip	Code)	
			O.C.M.E.			111	Penn	Str	eet B	altir	tore. M	D 2120	1		
<u>5</u>	permit. Pages 1 and Department of Health Important: if item 27 any injury or other tr once.		20a. Method of Disposition	_		Place of Disponentery, cre	osition (Nan	ne of			ate	20c. Location		own, State	
9	Pages nent of int: if it		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☑ Other (Spe	I⊟Removal from State	)	Jo.,,, 0,0,,,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		1						
Baltimore,	permit. Pa Departmen Important: any injury		21. Signature of Funeral Service Li	censee //			2. Name an	d Addre	ss of Facilit	ty					
ä	permit. Depart Import any inj		Ronald S	Wade, Dir	201	r S	tate A altimo	Anato	omy B	oard 21201		Baltim	ore S	treet	
	R W		23a. Part Enter the disease, or o	omplications that cause	d the dea							rest,		Approximat	te hygon
	Dhamisian		shock) or heart lailure. List of Immediate Cause (Final	. ,		fre	C	1	A 0 C	1	die are	ø		Onset and	Death
6.	Physician /Medical		disease or condition resulting in death)	a. HTUL N			Laro	ucu	as cul	54 0	distas				
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	uted 1 ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	V .											
,	exect n and ial-tra	Еха	resulting in death) Last	Due to (or as	s a consec	quence ol):									
760,	that the death certificate be executed ed by the attending physician and detached for use as the buriat-transit	cal		d											
68	ificat g phy as the			1											
Вох	ndin use	Physiclan/Medl	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			□Catania a					23d. Da	ate ol delive	эгу	
	death e atte d for	Cla	in the past 12 pronths?	1□Live birth 4□Pregnant a			□Ectopic pr □ Other (sp					M	onth	Day	Year
P.O.	t the	hys	9 Unknown	9□ Unknown							-				
	The law requires that the death certificat ate has been signed by the attending phypage 2 should be detached for use as the	y P	Part II. Other significant condition	s contributing to death	but not re	sulting in the	underlying o	ause giv	en in Part I		23e. Did to	obacco use con	tribute to the	he cause of o	death?
Ę	quire n sig uld b	pa									1 🗆 \	res 2□No	3 🗌 Prob	ably 4	Unknown
Records,	s bee	Completed by									24a. Was	an 24b.	Were auto	psy findings mpletion of a	available
Re	sician: The law certificate has b irector, page 2 s	E										rmed?	death?	2 No	ause oi
			25. Was case referred to medical						26 Place	e of Death	(Check only o		Yes	2L NO	
Ē	Physician: this certific ral director,	To Be	examiner? 1 X Yes 2 □ No	Hospital:	ient 2	ER/Outpatii	ent 3 DC	Oth				dence 6 XOti	her (Snecii	y SCEN	JE.
of	ding Physician: h. After this certific funeral director,		27. Magner of Death	28a. Date ol Inj (Month, D		28b. Time	of 2	28c. Injur Wor				now injury occur		" OCIAL	بندي
O	nding ath. r: After ie funei	ig Ig	Natural 5 ☐ Pending 2 ☐ Accident investiga		ay rear)	Injury	м		Yes 2□	No					
Division of Vital	Attendi r death. octor: A by the fu	floa	3 Suicide 6 Could no 4 Homicide determin	286. Place of It			treet, lactor	y, office			28l. Location (S City or Tox	Street and Num	ber or Rura	al Route Nun	nber,
Ö	afte afte	Certification:	4   Homicide	building, e	нс. ( <i>эрвс</i> і	η <b>γ</b> )					City of You	vii, State)			
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu			Physician: To the bes											
	P Ho P Fu	Medical	(Check only 2 Medical E	xaminer: On the basis and manner s		ation and/or	investigation	i, in my c	pinion, dea	ath occurr	ed at the time,	date and place,	and due to	o the cause(s	3)
	To th Withir To th	ž	29b. Signature and title of certifier		1	00	29		e number		100	29d. Date signe			
1			1 / las	11100	54	5		O C	ME		1	WV EMBE	R 2,	2005	
			30. Name and address of person w	ho completed cause of	death (Ite	m 23a)	e, Print)								
			ZABILICI	att A	4	227		PEN	N STR	EET,	BALTIM	ORE, MA	RYLAN	D, 212	201
8	St	ate	31. Date filed (Month, Day, Year)	32. Regis	trar's Sign		, ,								
1	Regist	rar	MOV 2 3	2005	120	1 A	CA COLL	0							

EARL THOMAS PARKER Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 05-07463 Amend Item #9,16a&b,17,18&19a&B Per INF C851 1/24/06 IH Hygiene State Unpend Item 23a&27 per me G849Caltificate of taxath 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** November 2005 Earl Thomas Parker /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c Prince Georges Examiner Prince George's Hospital Center Cheverly If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
Nov 15, 19 Social Security Numberunk 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ₹ M 2 □ F 48 Yrs. 1956 Director Washington DC Usual Residence of Decedent Maryland 10a. State unk 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show unk the Medical Examiner must be notified at unk unk 1 Yes 2 No Directo the 10e, Street and Number unk 10f. Zip Code 10g. Citizen of What Country? unk USA Itema 23a Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. and 16 marked other than "natural", or Itema 23 by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No U Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. unk 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry unk unk (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) unk Religion Minister unk other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnam unk Be <del>mk</del> 2 Earl Thomas Parker, Sr Nan Ellen Wallace 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5903 Fisher Road #13 Temple Hills, MD20748 19a. Informant's Name/Relationship (Type, Print) Tiretha L. Washington/sister 111 Penn Street Baltimore, Date 21201 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1 Department of H Important: If Ite any Injury or ot ang Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5 ☑Other (Specify) in state <sup>22.</sup> Name and Address of Facility State Anatomy Board 655 W. Baltimore Street 21. Signature of Euneral Service Licensee Ronald S. Wade, mar Baltimore, MD 21201 23a. Part Enter the disease/or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Asthma /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) anding physicien and use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) sete hes been signed by the page 2 should be detached in 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? Yes Yes 2 No : After this certification at funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No filled in by the within 24 hours after deat To the Funeral Director; 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) WO November 6, 2005 minte OCME

State Registrar 30. Name and address of person who com

ARGARITA

31. Date filed (Month, Day, Year)

Year) 32. Registrar's Signature

CORULE. Registrar's Signature

pleted cause of death (Item 23a) (Type, Print)

111 Penn Street

Baltimore, Maryland 21201

		1	For State	State of Maryland		rtment of			jienę eg. No.2005	37838
	*		Registrar  1. Decedent's Name (First, Middle, Last)					2. Date of Dea	th	3. Time of Death
	Physicia	ın		chard	Palm	er		November 1	19. 2005 Year	5:47p M
S 28	/Medic		4a. Facility Name (If not institution, give				, or Location of Deat		4c. County of Dea	
	Examin	C!	Anne Arundel Medica			Annapo	lis		Anne Aru	ndel
	Funeral		5. Social Security Number 6. Sec		st birthday)	If Under 1 Yea	ar If Under 24 Hrs		9. Bi	rthplace (State or Foreign ountry)
S .	Director	ļ	577-26 <b>-</b> 0039	₹ <sup>M 2□F</sup> 82_	Yrs.	Months Day	s Hours Min.	July 19		vland
	2	-	Usual Residence of Decedent		T					10d. Inside City Limits
-	show thow	_	10a. State 10b. County		Town or Loc	ation				1 ☐ Yes 2√ No
	Ba-f	octo	Maryland   Anne Arur	ndel Annaj	polis	1.2/ = 1.2			10g. Citizen of What C	•
	or 2	Directo	10e. Street and Number			10f. Zip Code			•	ourity:
	a 23a	rai	2545 Housley Road	12. Was Decedent Ever in U.S	13 W	2140	) <u> </u>	Specify Yes or No-	U.S.A.	erican Indian
,	itam Itam	Funerai	11. Marital Status 1 □ Never Married 2 ☑ Married	Armed Forces?	lf.	Yes, specify C	uban, Mexican, Puer	to Rican, etc.)	Black, Wh	
36	F, or	by F	3 Widowed 4 Divorced	1 DYes 2 No 1943 If Yes, Give Year or Dates: 1949		☐ Yes 2💢 N	lo Specify:		Specify: W	hite
21215-0036	tiled within 72 hours after death with free Maryland Hygiene, ther then "natural", or Itama 23a or 28a-f show ant, the Madical Examiner intellibe notified at	ed	15. Decedent's Edu	cation	16a. Decede	ent's Usual Occ	cupation	4	16b. Kind of Busines:	s/Industry
215	ole o	piet	(Specify only highest grad	e completed) College (1-4or 5+)	(Give k life. D	KIND OF WORK DOI OO NOT use ret	ne during most of wo ired)	nking		œ.
212	giene giene	Completed	9		Teleph	one Rep	air		Chesapeake &	Potamec Phone
_	0 - 0 -	Be	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle,	Maiden Surname)	
<u> a</u>	should b ind Ment s marked umatic e		Grover Heathcote	e Palmer			Lollie	Virgin		
Maryland	2 should be filed within 72 hours after dearn with the Marylan and Mental Hygiene. and Mental Hygiene is marked other than "natural", or Itama 23a or 28a-1 show aumatic event, the Madigal Exertitive Littlet by multified at		19a. Informant's Name/Relationship (Ty			-			r, City or Town, State,	
2	and m 27 ner tr	H	Donna P. Dotson- da	· · · · · · · · · · · · · · · · · · ·		North V sition (Name of	olverine	Rd., Pali	meř, Alask 20c. Location - City o	
Baltimore,	permit. Pages 1 and 2 should by Department of Health and Menta Important: If Item 27 is marked any Injury or other traumatic evonce.		20a. Method of Disposition 1 ☐ Burial 2   ☐ Cremation 3 ☐ F	Removal from State	metery, crem	natory or other p				
Ë	tant:		4 □Donation 5 □ Other (Specify)			emetory		3/2005	Falls Chur	cn, vA
3a	Depar Depar Impor any In		21. Signature of Funeral Service Licens	88	Ga	ry L. K	dress of Facility Caufman Fu	neral Ho	me at MMP,	INC.
- A	40240	$\dashv$	23a. Part1. Enter the disease, or compl	inations that caused the death	Do not ente	250 Wash	nington Bl	vd., Elk	ridge, MD	21075 Approximate
			shock, or heart failure. List only o	ne cause on each line.	. Do not sine				.031,	Approximate Interval Between Onset and Death
	hysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Cerebro		enlar	Accid	alt.		
	Examiner			Due to (or as a conseque	ence or):	Donal	Accid			
35.		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequence	ence of):	77791	MIN	<u></u>		
V .	uted J nnsit	min	cause. Enter Underlying Cause (Disease or injury that initiated events							
,	execting and and its its its its its its its its its its	Examiner	resulting in death) Last	Due to (or as a consequent	ence of):					
8760,	cate be executed physicien and the burial-transit	cai		d						
	tifica ng ph as th	Physician/Medical	IEEE I							
Вох	eath certific attending p	an/h	23b. was decedent pregnant	23c. If yes, outcome of pregnan 1 ☐ Live birth 2 ☐ Fetal		Ectopic pregna	ncy		23d. Date of d	elivery Day Year
о. П	the death certific y the attending p ached for use as	sici	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at time of de 9□Unknown	ath 5	Other (specify)				,
Ρ.	- 0 0	Phy		at inviting to death but not requi	Iting in the un	adashilaa aayaa	gues in Part I	23e Did to	bacco use contribute	to the cause of death?
	res tha signed be del	by	Part II. Other significant conditions co	Intributing to death but not resu	illing in the th	idenying cause	giveri ili r ait i.			Probably 4 Unknown
0	law requires as been sign 2 should be	eted								
Sec	nelaw hasb ge 2 s	Completed						24a. Was autop	sy prior to	autopsy findings available completion of cause of
<u>=</u>	ate pa							1 Tes	No 1 □ Ye	s 2 No
Zi:	Phyalcien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Othor	ath (Check only of		
of Vital Records,	Phys this ral dir	. To	1 Yes 2 No 27, Manner of Death	Inpatient 2 E	ER/Outpatien 28b. Time of	I 3 DOA	1 Unursing njury at Nork?		lence 6 Other (Sp	ecify)
no	ding h. After fune	tion	1 ⊠Natural 5 ☐ Pending	(Month, Day Year)	Injury		Nork? ∐Yes 2∐No			
<u>S</u>	Attending r death. ector: Afte by the fune	fica	3 Suicide 6 Could not be	28e. Place of Injury - At hor	me, farm, str	eet, factory, offi	се	28f. Location (S	Street and Number or I	Rural Route Number,
	after Dire	Certification:	4  Homicide	building, etc. (Specify,	)			City or Tow	vn, State)	
	spite	aic		ysician: To the best of my knov						
	To the Hospitel or Attending Physicien: within 24 hours atter death.  To the Funeral Director: After this certific completely filled in by the funeral director.	edicai	(Check only 2 Medical Exam one)	iner: On the basis of examinati and manner stated.	ion and/or inv	vestigation, in n	y opinion, death occ	urred at the time, o	date and place, and di	ue to the cause(s)
	事事	M	29b. Signature and title of certifier			29c. Lic	ense number		29d. Date signed (Moi	nth, Day, Year)
	F 3 F 8								111 - 11	
			A A CHOI	PRA		D	5 3028	5	11/20/0	
	(X)		30. Name and address of person who o	completed cause of death (Item			5 3028	01	11/26/8	
) _	15X1		30. Name and address of person who o		ay, An	napolis	5 }028 s, MD 214	01	11/248	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Americal Item 10e per fh 9849 11-23-05 vt.
State of Maryland / Department of Health and Mental Hygiene For Stata Registrar Certificate of Death Reg. No. UU 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** Month Gertrude Lowe November 17 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Northwest Randallstown Baltimore HOSPITCU Center 5. Social Security Number 7. Age (In yrs. last birthday) 1 Year Days 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Hours 1□ M % TyF 220-09-4348 89 Yrs Director Apr. 18, 1916 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 2 Show...
2 Montal Hygiene...
1 marked other then "natural", or items 23s or acc...
1 marked other then "natural", or items 23s or acc...
1 marked other then "natural", or items 23s or acc... Maryland Baltimore Owings Mills 1 ☐Yes 2 X No Directo 10e. Sea and Number 10f. Zip Code 10g. Citizen of What Country? 9217 Lyonswood Drive 21117 14. Race - American Indian, White, etc. Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify:White Completed by 3√ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Department Store Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Sales Person or other treumatic event, 17. Father's Name (First, Middle, Last) permit. Pages 1 end 2 should be file Department of Health and Mental Hy Important: if item 27 is marked oth any injury or other treumatic event <u>once</u>. 18. Mother's Name (First, Middle, Maiden Sumame) Be Unk. Unk. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leon Dickerson/ 9317 Lyonswood Drive Owings Mills, Md
and Disposition (Name of Date 20c. Location - City or Town, State friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Greenmount Cemetery 11/22/05 Baltimore, Maryland 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Chatman-HarrisFuneral Home 21. Signature of Funeral Service Licensee 5240 Reisterstown Rd Baltimore, Md 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheck, or hear failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** Gastrointestina nemorrhage /Medical Due to (or as a consequence of) Examiner intestinal ischemie Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Medical Certification; To Be Completed by Physiclan/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 1 ☐ Yes 2 ☐ No 4 Unknown Acute renal 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No chronic Kidney disease 24a. Was an autopsy performed/ Yes 2 No Protein calorie malnutrition certificate 1 Tes 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funerel Director: After the completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No М 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide ŏ To the Hospitel within 24 hours a To the Funerel C Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 17,2005 November 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospital Genter Randallstown, Maryland Bostor Northwest 31. Date filed (Month) Registrar's Signature 82 2 3 2005

State Registrar

		-	For State Registrer	State o	of Maryla	-	artment of H		nd Mental Hy	giene Reg. No 2   1   1   1	5 27010
A***	•		1, Decedent's Name (First, Middle, Las	t)					2. Date of De		3: Time of Death
	Physicia /Medic		Lucille S. Porter						Novemb		
)	Examin		4a. Facility Name (If not institution, give	street and nu	mber)		4b. City, Town, or	Location of I	Death	4c. County of D	eath
			Charlestown Retir	ement (	Communi	ty		consvi			altimore
	Funeral		Social Security Number     6. Security Number	x □ M 2 <b>X</b> F		s. last birthday)	If Under 1 Year Months Days	If Under 24 Hours	Min. (Month, Da	h y, Year) 9.1	Birthplace (State or Foreign Country)
14.	Director		290-03-3532 Superior Street St		87	Yrs.			Nov. 25	, 1917	New York
	land	1	10a. State 10b. County		10c. (	City, Town or Lo	ocation				10d. Inside City Limits
	Mary -1 sh	to	Maryland Baltim	ore		(	atonsvill	•			1 ☐ Yes 2 X No
	1 the	Director	10e. Street and Number	OIC .			10f. Zip Code			10g. Citizen of What	Country?
	h with		709 Maiden Choice	Lane			21228			United S	States
	death	Funeral	11. Marital Status	12. Was Dec Armed Fo	edent Ever in	U.S. 13.	Was Decedent of Hi	spanic Origin	n? (Specify Yes or No Puerto Rican, etc.)	- 14. Race - A Black, W	merican Indian,
9	or life		1 Never Married 2 Married	1 ☐ Yes If Yes, Gi	2∭No ve		1 ☐ Yes 2 🛣 No	Specify:		Specify:	White
8	72 hours after death with the Maryland "natural", or Itema 23a or 28a-1 show rdical Examiter neat be rediffed at	d by	3 N Widowed 4 □ Divorced	Year or C	Dates:	1 40- 0	di ada Ha at Oi a				
15-	c . 3	lete	15. Decedent's Ed (Specify only highest gra	de completed)		(Give	dent's Usual Occupa kind of work done of DO NOT use retired	lurina most o	f working	16b. Kind of Busine	ss/industry
21215-0036	filed within 72 ho Hygiene. other than "natur ent, the Wedical	Completed	Elementary/Secondary (0-12)	College (	1-4or 5+) <del> -</del>	Refe	rence Lib	raria	n.	U.S. Nav	val Academy
b	the the	Be C	17. Father's Name (First, Middle, Last)					18. Mother's	Name (First, Middle,	Maiden Sumame)	
Maryland	Q 22 Q	To B	James A. Kepley					Burtha	a Strickle	r	
lan	and and sum		19a. Informant's Name/Relationship (1	ype, Print)		19b. Maili	ng Address (Street a	and Number	or Rural Route Numbe	er, City or Town, State	e, Zip Code)
	1 and 2 Health Iem 27		Jennifer Porter /	Daugh t			Box 38018	33 Car	mbridge, M		
ore	0 0		20a. Method of Disposition 1 ☐ Burial 2 🕅 Cremation 3 ☐	Removal from	State	cemetery, cre-	sition (Name of matory or other place		Date	20c. Location - City	
Ë			* 4 □Donation 5 □ Other (Specify		Ва		Cremator				, Maryland
Baltimore,	permit. Pag Department Important: I any injury o	Michael John 177 Bake 01 610									neral Home, Inc is, MD 21401
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that one cause on e	caused the de each line.	ath. Do not en			rdiac or respiratory ar	rest.	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	а		D)	coul no	(4-4)			Onset and Death
	/Medical Examiner		resulting in death)	Due to	(or as a cons	equence of):					
240	xummer	_	Sequentially list conditions,	b. Due to	(or as a cons	equence of):					
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	00010	(0) 40 4 00//0	aquonos on.					
	al-tra	Exar	that initiated events resulting in death) Last	C. Due to	(or as a cons	equence of):					
8760,	ate be executed thysician and the burial-transit	cail	(	d							
9	tificat ng phy as th	led									
Вох	eath certific attending pl for use as t	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou	itcome of preg		Ectopic pregnancy			23d. Date of	
	The law requires that the death certificate be executed to a seem signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	in the past 12 months?		nant at time of		Other (specify)			Month	Day Year
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lo	Attending F r death. ector: After by the funer	atio	1. Natural 5 Pending 2 Accident investigation	,	nth, Day Year)	Injury		r Yes 2 □ No	·		
Division	er des recto by th	Certification:	3 Suicide 6 Could not be determined	286. Place	e of Injury - At	home, farm, st	reet, factory, office		28f. Location (5 City or Tox		Rural Route Number,
Ö	ital or A rs after al Directed in by		<b>/</b>		3, 1-7.						
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	edical	29a. Certifier 1/ Certifying Ph (Check only one) 2 Medical Exam	iner: On the b	e best of my k pasis of exami nner stated.	nowledge, deat nation and/or in	h occurred at the time vestigation, in my op-	ne, date and pointon, death	place, and due to the occurred at the time.	cause(s) and manner date and place, and c	as stated. due to the cause(s)
	To the To the comp	Me	29b. Signature and title of certifier	12.44	110		29c. License	number 2 C		29d. Date signed (Mo	onth. Day, Year)
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	5		10 am	- 64 7	11.4	acelli.	Print)	44 C	aug Co	Courte	W Md
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<b>K</b>	Physici	an	Decedent's Name (First, Min	ddle, Las							-	2. Date of De Month	Day	Year	3. Tim	e of Death
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Baltimore,	Pages 1 and the neut of He int: If item		20a. Method of Disposition 1 🛣 Burial 2 ☐ Crematic	on 3 🗍	Removal from :			Disposition (N r, crematory o				Date		· ·	r Town, State	
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	Physician		Im ediate Cause (Final d'sease or condition resulting in death)	_		cmic									24 h	nd Death
¥	/Medical Examiner		1830iiiig iii deaiii)	1	Hupe	or as a cons		f):							1000	ava
100		ner	Sequentially list conditions, if any, leading to immediate cause. Foter Underlying	,		or as a cons		f):							ic ye	(L-1
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760,	death certificate be executed e attending physician and id for use as the burial-transit	cal E		l	d.											
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Вох	eath certific attending pl	Physician/Med	23b. Was decedent pregnant in the past 12 months?			come of preg inth 2  Fo ant at time o	etal death	3 ☐Ectopic		,			230	I. Date of de Month	elivery Day	Year
o.		hysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		9□ Unkno			o 🗆 Other (	3pocny)							
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ita	ician: T certificat rector, pa	Be C	25. Was case referred to med examiner?	ical						26. Place	e of Deatl	1 Check only	2 No one	i 🗆 re	s ZLINO	
<u>&gt;</u>	Physician: r this certific ral director,	၉	1 ☐ Yes 2 No		-		□ ER/Out			4 🗆 INI		me 5 Res			ecity)	
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Division of Vital	Atter r dea ector by the	Certification:	3 ☐ Suicide 6 ☐ Coi	uld not be ermined	28e. Place	of Injury - Al	t home, far	m, street, fact	ory, office			28f. Location ( City or To	Street and N wn, State)	lumber or F	lural Route N	lumber,
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	To the Hospitel within 24 hours a To the Funerel I completely filled	dical			ysician: To the iner: On the ba and mant											se(s)
	To th within To th comp	Me	29b. Signature and title of cer	ifier				2	9c. Licens	e number			29d. Date s	igned (Mon	th, Day, Yea	r)
	4		1 (2)	4	~ 1	nD		710	RES-	000	)		Nove	mbe	V 21,	2005
	3		30. Name and address of pers	on who d	completed caus	e of death (I		Type, Print)	Pn 1	timo	W O	MD 2	11287	)		
Pull To	Sta		31. Date filed (Month, Day, Ye	ar)	32. R	egistrar's Sig		d	,	11110			- ( - 0 /			
100	Registr	ar	NOV 2 3	2005		150 6		2000								

State of Maryland / Department of Health and Mental Hygiene 37842 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Milton Potter Fayette November 1:30 p<sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1129 Boyd Road Street Harford | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | DEC 6 1943 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1 ☑ M 2 ☐ F 215 42 9423 61 Director MD Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location Show 10d. Inside City Limits itam 27 is marked other than "natural", or Itams 23a or 28a-f shov other traumatic event, the Mucinal Exprenent must be notified at 1 ☐ Yes 21 No Director Harford Street 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1129 Boyd Road 21154 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 Never Married 2 Marned Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🗓 No Specify: Specify: white Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Marine Engineer Marine 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be if Health and Mental Pages 1 and 2 should be Milton Favette Potter, Sr. Cecelia Krauk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Matt Potter - son 1129 Boyd Road, Street, MD 21154 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages
Department of the Important: If its any injury or of once. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory Inc 11/23/2005 Beltsville, MD 21. Signature of Funeral Service Licensee 22 Name and Address of Facility CAFA, Stephen D. Lohrmann, PA 8717 Green Pastures Drive, Towson, MD M00986 21286 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death cirrhosis Immediate Cause (Final disease or condition resulting in death) **Physician** months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, ause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dire to (unas a gunsequenca of) Examiner certificate be executed use as the burial-tran and Due to (or as a consequence of): Box 68760. physician Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? Year Month Day 5 Other (specify) P.O. 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, page 2 should be Alcoholism 2 ☑No 3 ☐ Probably 4 ☐ Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed certificate 1 Yes 2 4 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 Inpatient 2 ER/Outpatient 3 DOA funeral dir this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending To the Hospital or Attendir within 24 hours after death.
To tha Funaral Diractor: All completely filled in by the fu death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D35012 November 21, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) North Avenue Bel Air, Md 21014 J. Kevin CYNCH MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature Carles Registrar

			for State	State of Maryland	•					0000	07010
			Registrar		Cei	tificate of L	Jeath			2005	3/843
	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of Dea Month	Day	Year	3. Time of Death
4	/Media	cal	James A. Ricker					Novembe	_	7 2005	
N. Carlotte	Examir	ier	4a. Facility Name (If not institution, give s		İ	4b. City, Town, or		n		County of Deeth	
			5. Social Security Number 6. Sex		hirthday	If Under 1 Year	_	8. Date of Birth			
	Funeral Director			M 2□F 69	Yrs.	Months Days	Hours Min.		, Year)	9. Birti	nplece (State or Foreign untry) rginia
156			Usual Residence of Decedent	1 09				July 12	- p 1.	930 VI.	ıgınıa
	yland		10a. State 10b. County	10c. City, To	own or Lo	cation					10d. Inside City Limits
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	or 28	)Ire	10e. Street and Number		_	10f. Zip Code		1	10g. Citiz	zen of What Co	untry?
	23a	Funeral Director	7675 CEdar Drive			211	22			USA	
	r deg	ne		<ol><li>Was Decedent Ever in U.S. Armed Forces?</li></ol>	13. V	Was Decedent of Hi f Yes, specify Cubar	spanic Origin? (S	Specify Yes or No- to Rican, etc.)		14. Race - Amer Black, White	
36	be filed within 72 hours after death with the Maryland tal Hyglene. d other than "natural", or itams 23a or 28a-f ehow event, tre Madical Exicities mail te notified at	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 ☒ No If Yes, Give		I ☐ Yes 2√ No	Specify:	,			hite
Maryland 21215-0036	hour tural	d be	3 Widowed 4 Divorced	Year or Dates:			tion.			•	
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12	than the	шс	Elementary/Secondary (0-12)	Coltege (1-4or 5+)							
9	Hyg Hyg ent.		17. Father's Name (First, Middle, Last)			mailer	18. Mother's Na	me (First, Middle,	Maiden .	lewspape Sumame)	rs
au	id be entai ked ic ev	To Be	Leroy Ricker				T.i11i	an G. Ha	11		
ary	should nd Mer marke umatic	-	19a. Informant's Name/Relationship (Typ	pe, Print) 1	9b. Mailin	g Address (Street a				Town, State, Z	ip Code)
	and 2 salth a n 27 is		Patricia Ricker/s	oouse	7675	Cedar Dr	iva Paga	dana Mi	21	122	
Baltimore,	- I = E		20a. Method of Disposition	20b. Place	of Dispos	sition (Name of natory or other place				cation - City or T	Town, State
E	Pages nent of int: if it		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 14 ☑ Donation 5 ☐ Other (Specify)	emoval from State	,,		1				
<u>==</u>	permit. Page Department of Important: If any injury or once.		21. Signature of Fuheral Service License	1-12 11	22	Name and Addres	s of Facility	1 (55 17	D 1		
m	Depa Impo		Ronald S	ade rector		ate Anato			ват	timore	Street
6	7		23a. Part1. Enter the disease, or complice shock, of heart failure. List only on	e cause on each line.					est,		Approximate Interval Between
*	Physician		Immediate Cause (Final disease or condition	6004	estiv	e heart d	Tilure				Onset and Death
139	/Medical		resulting in death)	Due to (or as a consequence	e of):						
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	D #	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequent	ce of):			1			
	cate be executed physician and the burial-transit	каш	that initiated events resulting in death) Last	. Due to (or as a consequence	on of):						
8760,	be exician	E E		Due to (or as a consequent	<i>1</i> 6 01).						
387	phys the	dical	d								
9 ×	The law requires that the death certificate has been signed by the attending ragge 2 should be detached for use as	Completed by Physician/Me	IF FEMALE:	3c. If yes, outcome of pregnancy						3d. Date of deliv	
Вох	atter I for u	clar	in the past 12 months?	1 Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death		Ectopic pregnancy Other (specify)				Month Month	Day Year
P.O.	the d y the	lys	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown							
σ.	s that ned b	y P	Part II. Other significant conditions con		g in the ur	iderlying cause give	n in Part I.	23e. Did tot	bacco us	se contribute to	the cause of death?
rds S	n signe	D D	claset	is mellitus				1 <b>25</b> Ye	es 2	No 3∏Pro	bably 4 Unknown
00	aw requir as been si 2 should	lete						24a. Was a	ın	24b. Were aut	opsy findings available
Re	The lay	шо						autops	med?	prior to co	ompletion of cause of
ta	ician: Th certificate rector, pag	a)	25. Was case referred to medical				26 Place of Do	1 ☐ Yes 2 ath Check onl on	2/2940	1 🗆 Yes	2□ No
>	ysician: The Is certificate hadirector, page	To B	examiner? 1 ☐ Yes 2 € No H	ospital:	Outpatient	3 DOA Othe		lome 5 ☐ Reside		Cother (Special	(6)
0	를 를 풀	-	27. Manner of Death		. Time of	28c. Injury	at	28d. Describe ho			'97
0	ath. r: Aft	atlo	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Fear)	Injury	Work M 1 □ Y	es 2□No				
Division of Vital Records,	er de recto by th	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, stre	et, factory, office		28f. Location (St City or Town		Number or Rui	al Route Number,
	rs after salt bis all Dis	Cer		, (c, 10.7)				ony or row	i, olaloj		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.		29a. Certifier 1 Certifying Phys	ician: To the best of my knowled er: On the basis of examination	ige, death	occurred at the time	e, date and place	, and due to the ca	ause(s) a	and manner as	stated.
	the Prin 24 the F	Medical	5110)	and manner stated.						<del></del>	
	To Too	~	29b. Signature and title of certifler	Pays		29c. License				signed (Month,	
			+ ) ( box )	ייייי		0005	8719				7 7002
			30. Name and address of person who con  Albert Itaa M		Type, I	Print)	len Surn	IC MO	21	061	
	Sta	te	31. Date filed (Month, Day, Year)	32 Registrar's Signature		7114		4 1 7		- (	
- 31	Registr		0.000	A Ao	Park	Section 1					

DHMH 17 Rev 1/2001

Richer, James

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 5 per fh 8851 1-17-06 vt

1- State of Maryland / Department of Health and Mental Hygiene 1 5

1- State of Maryland / Department of Health and Mental Hygiene 1 5

Reg. No.

Reg. No. Ralph Rensberger 05-7171 37844 AKG 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year Ralph EAR RENSBERGER 23, October | 2005 /Medical Р 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 237 East 25th Street Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 311-03-2234 1 XM 2 ☐ F Director 86 Yrs. AUG 4. IN Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Completed by Funeral Director MD BALTIMORF 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 237 EAST 25TH ST USA Items 23a Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.
int: If item 27 le marked other than "natural", or Items 23. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Never Married 2 ☐ Married 1 ☐ Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 ö 1 ☐ Yes 2X No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) TOOL & DIE MAKER MERCHANT MARINES 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental ! KENTON EARL RENSBERGER ALBERTA DENA JANSSEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROBERT item 27 I 818 GREEN PINE CT. APT B, MISHAWAKA, IN 46545 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🗷 Cremation 3 🗷 Removal from State 5 permit. Page Department or Important: If eny injury or once. BAYVIEW CREMATORY 4 □ Donation 5 □ Other (Specify) 111.17, 2005 BALTIMORE, MD 22. Name and Address of Facility
FINK FUNERAL HOME P.A.
426 CRAIN HWY SW GIEN BURNIE MD 21061 21. Signature of Funeral Service L 23a. Pant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in dealh) **Physician** Hypertensive atherosclerotic cardiovascular disease /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed nding physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as the 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death Day 5 Other (specify) been signed by the s should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ nknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

120 es 2 \sum No 24a. Was an autopsy performed? certificete 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other:  $_{4}\square$  Nursing Home  $_{5}\square$  Residence  $_{5}\square$ Other (Specify) at SCENE P Yes 2 No this After the funeral of 27. Magner of Death 1 ANatural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation Injury death. I Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dire Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated o the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME 30. Name and address of person who completed cause of death (item 23a) (Type, Print) 111 Penn Street Baltimore, Maryland 21201 October 24, 2005 THE ODDRE MIKING 32. Segistrar's Signature 31. Date filed (Month, Day, Year)
NOV 2 3 2005 State Registrar

			1 - State Registrar	State of M	laryland / [	epartmer <i>Certifica</i>	nt of H	ealth and I Death		giene () (	J 5	37845
i .	Physici	an	Decedent's Name (First, Middle, Last						2. Date of Dea	Day, A	Year	3. Time of Death
	/Medio	al	JOHN RIVERS JR  4a. Facility Name (If not institution, give		) _ (	4b, City	, Town, or	Location of Death	Novemb	<del>(* 17.</del>	y of Death	DIJOH "
	LAdiiii	ici	Mariland Ger	neral H	Ospita	I Rai	time	ore (in	+4	N/	A	
	Funeral Director		207 02 1712	ex 7. A □ M 2□ F	ge (In yrs. last bin 63	hday) If Unde Months	Days	If Under 24 Hrs. Hours Min.	/8. Date of Birt (Month, Da) 2-4-1	h v. <i>Year)</i> 942		place (State or Foreign ntry) RTH CAROLIN
	and and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location		<del></del>			1	0d. Inside City Limits
	death with the Maryland ms 23a or 28a-f show f must be notified at	tor	MD. N/A		BAL	TIMORE						1∭Yes 2 No
	or 286	Director	10e. Street and Number			10f. Zi	p Code			10g. Citizen of	What Cour	ntry?
	s 23e or		614 MURPHY LAN		- Francis II S		21201			USA	ce - Americ	an Indian
336	urs after de al', or Item	by Funeral	11. Marital Status  1 Never Married 2X Married  3 Widowed 4 Divorced	12. Was Deceden Armed Forces 1 ∑ Yes 2 ☐ If Yes, Give Year or Dates:	? No	If Yes, spe		Specify:	pecify Yes or No- o Rican, etc.)	Bla	ce - Americ ck, White, fy: BLA	etc.
215-0036	filed within 72 hours after Hygiene. sther than "neturel", or Ite ent, I're Medical Examine	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	lucation de completed) College (1-4or	16a. 5+)	Decedent's Usu (Give kind of we life. DO NOT u	ial Occupa ork done di use retired)	tion uring most of wor	rking	16b. Kind of 8	Business/In	dustry
72	filed w Hygier other the		-12- 17. Father's Name (First, Middle, Last)	-0-	D	RIVER		18 Mother's Nan	ne (First, Middle,			ATION
Tylanc Tylanc	e d la b	To Be	GEORGE RIVERS						A MASON	Walder Some	1110)	
A Z	S D F F	-	19a. Informant's Name/Relationship (		19b	-			ıral Route Numbe	-		
Σ	1 and 2 Health a em 27 is		BEATRICE RIVER	S(WIFE)	100h Bl			LANE BA	ALTIMORE			
DHA altimore,	Pages 1 ar		20a. Method of Disposition 1 □ Burial 2 □ Oremation 3 □		cemeter	Disposition (Na y, crematory or	other place	´ 1	Date	20c. Location	-	
10	C & -		' 4 ☐ Donation	) JONAZHA	GARRIS N D. HTB	ON FORE: NEÆ: Name a	Od Address	TERANS I	LLIPS FU	OWINGS INERAL	HOME	S MARYLAN
/ Jag	permit. Depart Import eny inj		faratte (	J. HUB	ne							LAND 21217
•	Physician /Medical		23a. Party Enter the disease, or company, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a.Sover	d the death. Do r	nona	de of dying	such as cardiac	CNS 10	rest,		Approximate Interval Between Onset and Death
8760,	cate be executed by physician and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	. Kescii	UC TIVE s a consequence of	Acia	O AI OSi	onea S				
Box 6	aath certifii attending p for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		e of pregnancy 2  Fetal death at time of death	3 □Ectopic p 5 □ Other (s					ate of delive	ory Day Year
ls, P.O.	wrequires that the deben signed by the should be detached	þ	Part II. Other significant conditions of	ontributing to death	but not resulting in	the underlying	cause give	n in Part I.	1	bacco use con	tribute to th	ne cause of death?
Soro	requi	Completed							24a. Was a			
Rec	he lav e has age 2	Jumo							autop: perfor	med2	death?	psy findings available inpletion of cause of
ital	en: T rtificat tor, pa	Be Co	25. Was case referred to medical				-	26. Place of Dea	1 ☐ Yes ith (Check only or		1 🗆 Yes	2 L No
>	Physicien: r this certifica ral director, I	10	examiner? 1 Tes 2 No	Hospital: 1 1 Inpat			the state of the state of	4   Nursing H	ome 5 Resid			1)
o uc	ding P	ion:	27. Manner of Death  1   Natural 5   Pending  2   Accident investigation	28a. Date of Inj (Month, Da	ury 28b. T ay Year) Ir	ime of njury M	28c. Injury Work' 1 □ Y	at ? es 2 □ No	28d. Describe h	ow injury occur	rred	
Division of Vital Records,	To the Hospital or Attending Physicien: The law within 24 hours after death.  To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In	ijury - At home, fai tc. <i>(Specify)</i>			02 2 2 110	28f. Location (S City or Tow	treet and Numi n, State)	ber or Rura	I Route Number,
	le Hospita 124 hours e Funerel letely filler	Medical C	29a. Certifier 1 Tertifying Ph (Check only one) 2 Medical Exam	y <b>sician</b> : To the besi niner; On the basis of and manners	of examination and	, death occurred Dor investigation	at the time	e, date and place inion, death occu	, and due to the c rred at the time, c	ause(s) and m late and place,	anner as st and due to	ated. the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	- ,,,		29	c. License	number no	FIN 3	29d. Date signe	d (Month,	Day, Year)
			DAMA CHUKMU,					89.	244 1	JUVEM	Der-	14,2005
15			30. Name and address of person who	completed cause of	death (Item 23a) (	Type, Print)	Inri	Iland !	1ANA	11 H	Kn's	101
2	Sta	ite	31. Date filed (Month, Day, Year)	32. Regist	rar's Signature	Sale	E /	14.4	4-11-	-110	TIL	ч ,
	Registi	ar	2 2 7	005	155 SEST	100						

,	-		For State Registrer		epartment of Health and Certificate of Death	d Mental Hygie	211115	37846
	Physici	an	Decedent's Name (First, Middle, Last)	Par	usou	2. Date of Death Month	Day Year	3. Time of Death
	/Medio Examin		MACAR THEE  4a. Facility Name (If not institution, give street a)		4b. City, Town, or Location of De	NEVENUSE	4c. County of Deat	ATI
	Exami	ei		Spital CENTE	· ·	Town	BALT	ines =
	Funeral		5. Social Security Number 6. Sex,	7. Age (In yrs. last birtho	day) If Under 1 Year If Under 24 Hours M		9. Birt	hplace (State or Foreign
	Director		Usual Residence of Decedent	4 1 Yr	S	Marcit 10,	1964 1R1	N Jork
	ow ow		10a. State 10b. County	10c. City, Town c	or Location	r		10d. Iriside City Limits
	e-feh	ţċ	ma. NA	- 15	Xetternoe			1XYes 2 □ No
	or 28	Director	10e. Street and Number	C 1	10f. Zip Code	10g.	Citizen of What Co	untry?
	hours efter death with the Maryland tural; or Itams 23a or 28e-f ehow al Ezdningtonal becomilled at		22 Jorlina	Court	2120,	/	200	7
10	ter de	Funeral	11. Marital Status 12. Was Arm 1 □ Never Married 2 Married 1 □	Decedent Ever in U.S. ed Forces? Yes 2 DNo	<ol> <li>Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu</li> </ol>	(Specify Yes or No- erto Rican, etc.)	14. Race - Ame Black, White	
5-0036	al', or	þ	If Ye	es, Give / r or Dates:	1 ☐ Yes 2. No Specify:		Specify:	Dack
50	72 hours natural; dical Ex	eted	15. Decedent's Education (Specify only highest grade compl	eted) ((	ecedent's Usual Occupation Give kind of work done during most of v		. Kind of Business/	Industry
121	s within 72 ho piene. r than "natu	Completed	Elementary/Secondary (0-12) Coll	ege (1-4or 5+)	ife. DO NOT use retired)	3	hedexo.	-marrioTT
d 21	be filed tal Hygid d other event.	Be Co	17. Father's Name (First, Middle, Last)	Jan.		lame (First, Middle, Maid	den Sumame)	
<u>lan</u>		To B			unknam			unknown
Marylan	2 sh and is m		19a. Informant's Name/Relationship (Type, Prin		Mailing Address (Street and Number or	Rural Route Number, Ci	y or Town, State, 2	Zip Code)
-	s 1 and 7 f Health Item 27 other tr		Vanessa I Robinson		Torlina Ct Bal	timore ma	1, 2, 20 T	7
סר	0 0 = =		20a. Method of Disposition  1 ■ Burial 2 □ Cremation 3 □ Removal		risposition (Name of crematory or other place)			/
altimore	permit. Pag Department Important: any injury c		' 4 ☐ Donation S☐ Other (Specify)  21. Signature of Fy eral Service Livensee	KING			undalls	form, md.
Ba	permit. Departir Imports any inju		Mart 1 may		22. Name and Address of Facility	Erneral Hu	as motor	md. 21229
			23a. Parti Enter the disease, or complications shock, or heart failure. List only one cause	that caused the death. Do not	t enter the mode of dying, such as card		ra Parcelo	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		21-14			Onset and Death
	/Medical Examiner		resulting in death)	PNEUM ( ue to (or as a consequence of)		3 6		
		er	Sequentially list conditions, if any, leading to immediate	DNEUMC (or as a consequence of)	Lystes CARI	VII		
	d d ansit	Examin		PSEUDSILL ue to (or as a consequence of)		11084		
oʻ	sate be executed obysicien and the burial-transit		resulting in death) Last	e to (or as a consequence of)	:			
8760	the the	dicai	d					
9 X	The law requires that the death certific ste has been signed by the attending p tage 2 should be detached for use as	Physician/Me	IF FEMALE: 23c. If ye	s, outcome of pregnancy			22d Date of deli	von.
Вох	death a atter d for u	iciar	in the past 12 months?	Live birth 2 Fetal death Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of deli Month	Day Year
P.O.	at the d by the tached	hys	9 Unknown	Unknown		Ţ		
	es tha igned be de	þ	Part II. Other significant conditions contributing	to death but not resulting in the	ne underlying cause given in Part I.			the cause of death?
ord	w requir been si should I	eted	HIV POSITIVE;	RESPIRAL	cry thilune	1 🗆 Yes	2 12 No 3 □ Pro	obably 4 Unknown
Records,	The law ate has b page 2 s	Completed			,	24a. Was an autopsy performed	prior to c	topsy findings available completion of cause of
a		e Co	25. Was case referred to medical			1 ☐ Yes 2 🖫		21140
Vital	Physiclan: this certific ral director.	0 8	examiner?  1 Yes 2 1 No	1 Impatient 2 ER/Outpa	Other	eath (Check only one) Home 5 - Residence	6 □Other /Sner	rife)
J of		T:uc		Date of Injury (Month, Day Year) 28b. Tim	ne of 28c. Injury at	28d. Describe how in		
Siol	Attendir death. ctor: Af y the fu	catic	2 Accident investigation		M 1 Yes 2 No			
Division	or Att	Certification:	3 Suicide 6 Could not be determined 28e.	Place of Injury · At home, farm building, etc. (Specify)	, street, factory, office	28f. Location (Street City or Town, St		ral Route Number,
	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the fune		29a. Certifier 1 Certifying Physician:	to the best of my knowledge, o	death occurred at the time, date and pla	ce and due to the cause	(s) and manner as	stated
	ne Hos n 24 h ne Fur sletely	edical	(Check only 2 Medical Examiner: On	the basis of examination and/o manner stated.	or investigation, in my opinion, death oc	curred at the time, date a	and place, and due	to the cause(s)
	To the To the Comp	M	29b. Signature and title of certifier	*	29c. License number		Date signed (Month	
)			1 Mary	> huj	0 1950	No	vanfor	21, 2005
	6		30. Name and address of person who completed	1	rpe, Print)	e THWEST	HESPI	21, 2005 AL COUTE 21133
	Sta	te	31. Date filed (Month, Day, Year)	32. egistrar's Signature —	KANDALL	Stown, R	oryland)	21133
	Registr	-	NOV 2 3 2005	32. Registrar's Signature	Good			

			1 - For State Registrar	State of Ma		epartment Certificate			d Mental Hy	giene 0 0	5 37847
ı	Physici		Decedent's Name (First, Middle, Last		Ardella F	Rattini			2. Date of De Month	Day Y	ear 11:35 M
	/Medio		4a. Facility Name (If not institution, give	street and number) es Villa	je	4b. City, 1 Ba	ltim	ocation of De	eath ty	4c. County of	
	Funeral Director		5. Social Security Number  212-03-7733  Usual Residence of Decedent	TM OFFE	e (In yrs. last birth	Months	1 Year Days	If Under 24 H Hours M	Irs. 8. Date of Bir (Month, Da OCt. 1	y Year)	n. Birthplace (State or Foreign Country) Iaryland
	ne Maryland 8a-f ehow Alified at	Director	10a. State 10b. County  Maryland N/A		10c. City, Town			timore	City		10d. Inside City Limits 13€ Yes 2 □ No
	3a or 2		10e. Street and Number $304 \text{ S. High Stre}$	et		10f. Zip	Code	2120	2	10g. Citizen of Wh	
036	be filad within 72 hours atter death with the Maryland ital Hygiene. ad other then "naturel", or itams 23e or 28e-f ehow avent, the Medical Examinational to indified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:		13. Was Decedif Yes, spec			(Specify Yes or No erto Rican, etc.)		American Indian, White, etc. White
21215-0036	within 72 ho ane. than "natur	Completed	15. Decedent's Edu (Specify only highest grad			Give kind of won	k doné du e retired)	ion ring most of v	vorking	16b. Kind of Busin	,
9	d 2 should be filad within h and Mental Hygiene. 7 is markad othar than " traumatic avant, the Mas	Be Co	12 Years 17. Father's Name (First, Middle, Last)			Manage		8. Mother's N	lame (First, Middle,	Insura Maiden Sumame)	ince
Maryland	ould be Menta arkad atic av	To B	John Boyd						Stella S.		
			19a. Informant's Name/Relationship (T) Mr. Joseph Ratti			Mailing Address  4 S. Hi			Rural Route Number Baltimor	er, City or Town, St. e, Maryla	
Baltimore,	permit. Pages 1 and 3 Dapartment of Health Important: if itam 27 any injury or other tri once.		20a. Method of Disposition     Maria   2 □ Cremation   3 □ F    4 □ Donation   4 □ Other (Specify)	Removal from State	cemetery,	Disposition (Name crematory or other Cem	her place)	1 .	Date	20c. Location - Ci	
Baltii	permit. Pages i Dapartment of H Important: if its any injury or ot once.		21. Signature of theral Solvice Licens	Find In	11/1	22. Name and Duda – Ru	Address Ck F1	of Facility Ineral	Home of Dundalk,	Dundalk,	Inc.
	cate be executed /Medical Examiner the burial-transit	al Examiner	23a. Part1. Enter the disease, or compishock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that inditated events resulting in death) Last	Due to (or as	a consequence of	n Why B	of dying.		iac or respiratory a	rest,	Approximate Interval Between Onset and Death Years
O. Box 687	The law requires that the death certificate te has been signed by the attending physioage 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death	3 □Ectopic pre 5 □ Other (spe				23d. Date of Month	f delivery Day Year
rds, P	quires that n signed b uld be deta	by	Part II. Other significant conditions con	ntributing to death b	ut not resulting in t	ne underlying ca	use given	in Part I.			ite to the cause of death?  Probably 4 Unknown
		Completed								prio prio dea 2 No 1 □	e autopsy findings available r to completion of cause of th? Yes 2 No
	iing Phys n. After this funaral dii	ation: To Be	25. Was case referred to medical examiner?  1	fospital: 1  Inpatie 28a. Date of Inju (Month, Dat		ne of 28	Other: c. Injury a Work?	4 Nursing	Heath Check on o Home 5 Residues Residues Pada Describe h		Specify)
=	or Dir	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, etc.	ury - At home, farm c. (Specify)	, street, factory,	office		28f. Location (S City or Tow		or Rural Route Number,
	H T H	Medical (	29a. Cartifier (Check only one)  1 Certifying Physical Examination (Check only one)	sician: To the best oner: On the basis of and manner sta	examination and/o	death occurred a or investigation, i	t the time in my opir	date and pla	ce, and due to the courred at the time, o	cause(s) and mannedate and place, and	er as stated. due to the cause(s)
	To the within 2 To the complete	Σ	29b. Signature and title of certifies	Thow from	, md, cmb,		License r	CIRCR	·   v	29d. Date signed (A	onth, Day, Year)
0	T		, , , , , , , , , , , , , , , , , , , ,	St. Kaul	Place	pe, Print) # 701	Ba	uti mo	u, mb	21202	
	Sta Registr		31. Date filed (Month, Day, Year) NOV 2 3 200	32 Registra	ar's Signature	carles					

CTELLS A. PATTINI

State of Maryland / Department of Health and Mental Hygie 🏖 🛭 🖯 5 37848 Certificate of Death 2 Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** KENNETH 2005 9:50 PM SZYMANSKI 11 NOV /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner UNIVERSITY OF MARYLAND MEDICAL CENTRA BALTIMORE If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) **Funeral** 1 ₹M 2 □ F unk Director 214-46-0568 May 20, 1947 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or itema 23a or 28a-f show the Modest Examiner must be notified at 1√ Yes 2 □ No Director MD Brooklyn 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 25 W. Bristol Avenue #B 21225 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 ☑ No Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation unk 16b Kind of Business/Industry unk (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygier Important: if item 27 is marked other it any injury or other traumatic event, the pnce. unk unk 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) **UMMS** 22 S. Greene Street Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5 NOther (Specify) in state 21. Signatur of Funeral Source Licensee Rollald Source 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Pan1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** a MYDOARDIAL INFARCTION disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CEREBROVASCULAR ALCIDENT Eggentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine The law requires that the death certificate be executed ettending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4 Pregnant at time of death 5 ☐ Other (specify) signed by the e 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 Yes 2 No 3 Probably 4 Unknown been si Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? this certificete hes al director, page 2 performed? 1 Yes 2 No 2 No 1 Yes To the Hospitei or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 2 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After the funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Director: / 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours after To the Funeral Dire 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medica 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of configer 29d. Date signed (Month, Day, Year) 29c. License number MD 16583 NOV 12 ,

DHMH 17 Rev 1/2001

State

Registrar

ST.

BALTIMORE.

MD

21201

S. GREENE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

22

32, Registrar's Signature

BOUGHAN

NOV 2 3 2005

31. Date filed (Month, Day, Year)

			State of Maryland / Department of Health and M - For Amend Items# 7&8 per FH G849 11/23/05 Continued to the state of Death	lental Hyg	iene	37849
	Physicia	an	1. Decedent's Name (First, Middle, Last)  Mark R. Stunsf	2. Date of Deat Month	h Day Yeer	3. Time of Death p 6 03:32 M
9	/Medic Examin	er	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death		4c. County of Dea	th
			Peninsula Regional Medical Center Salisbury  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Hunder 1 Year Hunder 4 Hrs.	8. Date of Birth	9-23-51 9 Bi	thplace (State or Foreign
	Funeral Director		212-58-23/66 1tDM 20F 54 52 Yrs. Months Days Hours Min.	(Month, Day,	Year) C	ountry) (M)
	pu .		Usuel Residence of Decedent  10a, State 10b, County 10c, City, Town or Location	7		10d. Inside City Limits
	Maryli	ţō	MD Baltimore Dundalk			1 Tyes 2 PNo
	th the	Director	10e, Street and Number 10f. Zip Code	1	0g. Citizen of What C	ountry?
	s 23s	rai	7407 alvah Avenue 21222	and Managhia	14. Race - Am	ocore Indian
·0	fter de	Funerat	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married  12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, Whi	te, etc.
5-0036	within 72 hours after death with the Maryland ene. then "neture!', or items 23s or 28s-1 ehow the Medical Examinar must be rediffed at	þ	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:		Specify: U	hite
5	n 72 h	olete	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of worki life. DO NOT use retired)	ing	16b. Kind of Business	1
212	d with giene.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)  2 Warehouse Man	2	Warehouse	teeminal
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. Item 27 is marked other then "neturel", or items 23s or 28s-f ehow other treumatic event, the Medical Examinal must be rediffied at	Be	17. Father's Name (First, Middle, Last)  Richard Stumpf, JR.  18. Mother's Name  Griori		Bandy	
2	and Men is marke	2	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Ruce		- 1	Zip Code)
	and 2 lealth a m 27 is		Therese Stumpt - wife 7407 alvah Ave.	undali	K, mb	21222
ore	Peges 1		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Place of Disposition (Name of cemetery, crematory or other place)	Date /	20c. Location - City of	Town, State
Baltimore,			4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee  22. Name and Address of Fagility	3/05	Balhmore	7.A.
Ba	permit. Departr Importa eny inji		Little & asher Bradley-NSAFO	SACING	Rd. 21	
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of shock, or heart failure. List only one cause on each line.	or respiratory arri	est,	Approximate Interval Between Onset and Death
S. Sand	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. VENT LICENT TRUTYCARDA, SIP COLUMNARY (resulting in death)	serely ex	1825S	20245
	Examiner		Due to (or as a consequence of):  Sequentially list conditions  b. Colomacky Markly DISFASE			YEVES
-	sit ad	liner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
	sicien and burial-transit	Examiner	resulting in death) Last  C.  Due to (or as a consequence of):			
3760,	2 2 0	cai	d			
x 68	ertifica ding ph	/Med	IF FEMALE: 23c. If yes, outcome of pregnancy		201 0 (1	15
Box	death death	by Physician/Med	in the past 12 months?    Compared to the continuous co		23d. Date of de Month	Day Year
P.0.	at the	Phys	9 ☐ Unknown	age Dident		a the accuse of death?
rds,	w requires that the death certific been signed by the attending p should be detached for use as		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		bacco use contribute l es 2□No 3□F	robably 4 Unknown
Division of Vital Records,	e ia hes je 2	Completed		24a. Was a autops	v prior to	utopsy findings available completion of cause of
ta		Be Co	25. Was case referred to medical 26. Place of Death		2 □ No 1 □ Ye	s 2 <b>/2</b> 4/No
× ×	9 (0 =	ToE			ence 6 Other (Sp.	ecify)
ouo	After fune	tlon:	1 Natural 5 Pending (Month, Day Year) Injury Work?	28d. Describe ho	ow injury occurred	
Visi	Attending or death.  ector: After by the funer	ertification;	Accident	28f. Location (St City or Town	treet and Number or F	Rural Route Number,
Ö	Hospital or 4 hours afte Funersi Directed in 1	O				
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner, stated.	and due to the cared at the time, d	ause(s) and manner a late and place, and du	e to the cause(s)
	Vithir To th	ž	29b. Signature and title of centrier 29c. License number	2	9d. Date signed (Mon	ith, Dey, Year)
,	~/		29b. Signature and title of certifier  29c. License number  29c. License		11-22	-2005
(	1		James Todd 100 E. CANNO! ST. S.	141564	ing mo	
Q	Sta Regista		31. Date filed (Month, Day, Year)  32. Registrar's Signature		/	
	negisti	all	MOV 2 3 2005 Believe & Apple			

State of Maryland / Department of Health and Mental Hygiene 15 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** November 22, 2005 Richard J. Sienkiewicz 2:38A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Good Samaritan Hospital Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 M 2□ F Months Dec12,1927 Maryland Director 216-20-5431 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County 28a-f show other treumatic event, the Medical Examiner must be notified at 1⊠Yes 2 No Baltimore n/a Md. Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5 238 21206 USA 5437 Pembroke Avenue by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 0 1 ☐ Yes 2√2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced "naturel" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) then " College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien. Importent: If item 27 Is marked other the any injury or other treumatic event. The page. 12th Paper Hanger Self Employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Peter Sienkiewicz Stella Wisniewski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5437 Pembroke Avenue Baltimore, Md 21206 Margaret Sienkiewicz/wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1√ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Holy Rosary Cem. 11/26/05 Baltimore, 22. Name and Address of Facilit Kaczorowski Funeral Home, PA 21. Signature of Funeral Service Licensee 1201 Dundalk Avenue Baltimore, Md. 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final GALLBLADDER METASTATIC months Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner Hospitel or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IE EEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav in the past 12 months? 4 Pregnant at time of death 5 Other (specify) P.0. 9 Unknown the 9 Unknown 23e. Did tobacco use contribute to the cause of death? as been signed 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records. typer fension 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 1 ☐ Yes 2 ☑ No 1 Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner' Hospital: 1 ☐ Inpatient 2 🔀 ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 ▼ No 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural
2 Accident death. 1 ☐ Yes 2 ☐ No investigation after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) à 4 Homicide hin 24 hours a the Funeral I 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 22, 2005 27. D40480 November Belgin 7602 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ricial Forno, ms Baltimoro FERNANDO 21236 32 legistrar's Signature 31. Date filed (Month, Day, Year) med NOV 2 3 2005 A Second Registrar

		1	- FOI	artment of Health and Men	ntal Hygien Reg. N	2005 27051
	Physicia	an	1. Decedent's Name (First, Middle, Last)  Clyde Smith		Date of Death Month Di Ovember	3. Time of Death 10 2005 8:00A M
<b>)</b> -	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4	c. County of Death
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	Shady Side    If Under 1 Year   If Under 24 Hrs.   8   1   1   1   1   1   1   1   1   1	Date of Birth (Month, Day, Year	nne Arundel  9. Birthplace (State or Foreign Country)
	Director		219-26-4723   120 M 2 □ F   65 Yrs.  Usuel Residence of Decedent		ov 21 1	939 Maryland
	aryland show	_	10a. State 10b. County 10c. City, Town or L			10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	the Ma	Directo	Maryland Anne Arundel Shady S	10f. Zip Code	10g. C	itizen of What Country?
	ath with 23a or unt be	rai Di	5323 Al Jones Dr.	20764		ISA
2-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of heelth and Mental Hygiene. Depertment of heelth and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any figury or other traumatic event, the Medical Expiritive must be notified at once.	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rica  1 ☐ Yes 2  No Specify:	Yes or No- an, etc.)	14. Race - American Indian, Black, White, etc.  Specify: Black
21215-0	within 72 ho ine. Ihan "natur ie Med cal	Completed	(Specify only highest grade completed) (Give Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation e kind of work done during most of working DO NOT use retired)		Kind of Business/Industry
N	e filed v	Be Co	10th 0 T1  17. Father's Name (First, Middle, Last)	ruck Driver  18. Mother's Name (Fit		ney Enterprises on Sumame)
Maryland	d Menta	10	Clyde Smith  19a, Informant's Name/Relationship (Type, Print)  19b. Mail	Mabel Smi		or Town State 7in Code)
	and 2 si eith an 127 ia r er traur			3 Al Jones Dr. Sh	ady Sid	e, Md. 20764
Baltimore,	Pages 1 ament of He ant: if Item ury or oth		1 QBunal 2 Cremation 3 Hemoval from State 4 Donation 5 Dother (Specify)  Moses (	Cemetery 11-16	-05 Dru	Location - City or Town, State
Balt	permit. Depertimon fimbort any injustral			22. Name and Address of Facility Wm. Reese & Sons 1 821 West St. Anna		
Ī			23a, Part1. Enter the disease, or complicetions that caused the death. Do not en shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac or re-	spiratory arrest,	Approximate Interval Between
7	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. Dillate 1  Due to (or as a consequence of):	CArdio myop.	Athy	,
	Examiner	_	Antronsole	erotic Heart	Diser	75-1
	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events  b. Due to (or as a consequence of):	Mellitas		
8760,	ate be executed obysicien and the burial-transit	icai Ex	resulting in death) Last Due to (or as a consequence of):	•		
687	rtificate ng phys as the	Medic	IF FEMALE:			
P.O. Box 6	The law requires that the death certificate be executed to has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Med	23b. Was decedent pregnant    1	□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
	w requires that been signed by should be deta		Part II. Other significant conditions contributing to death but not resulting in the Carre Prostate, Cerebrovas	scular Accident,		o use contribute to the cause of death?
Division of Vital Records,	: The law requicele has been page 2 should	Completed by	Chronic Renal FAIlure.		24a. Was an autopsy performed? 1☐ Yes 2☐	24b. Were autopsy findings available prior to completion of cause of death?  1  Yes 2 No
Vita	rsician s certific director	To Be	25. Was case referred to medical examiner?  1   Yes 2   No	26. Place of Death (Cl	16	6 □Other (Specify)
ou of	iing Phy Atter thi funeral o		27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time (Month, Day Year) Injury	of 28c. Injury at 28d.	. Describe how inj	
Divisio	To the Hospital or Attending Physician: The I within 24 hours after deeth.  To the Funeral Director: After this certificete ha completely filled in by the funeral director, page	Certification;	2 Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, si building, etc. (Specify)		Location (Street a City or Town, Sta	and Number or Rural Route Number, ite)
	he Hospita n 24 hours he Funeral pletely fille	edical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, deal on the basis of examination and/or in and manner stated.			
)	Tot com	Σ	29b. Signature and title of certifier  Milliein Papers mo	29c. License number  D0006654		oate signed (Month, Day, Year)
6	1		30. Name and address of person who completed cause of death (Item 23a) (Type William P. Jones, m.D. C	131 Shady Side	Rd.	20764
	Sta Regist		31. Date filed (Month, Day, Year)  NOV 2 3 2005  32 Registrar's Signature	nte		

State of Maryland / Department of Health and Mental Hygiene 0 0 5 37852 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2, Date of Death 3. Time of Death Year Month **Physician** Lethia E. Simms 5:00P M November 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Millennium @ South River Edgewater Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 25 F 84 Yrs. 214-12-0630 Director 1921 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be netified at Maryland Anne Arundel
10e. Street and Number
5186 Sanda Rd 1 Tes 2 No Lothian 10f. Zip Code 10g, Citizen of What Country? 20711 USA 5186 Sands Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status should be filed within 72 hours after on Mental Hygiene. marked other than "natural", or Ite. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ XNo Specify: Black δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Private Family Domestic 3rd permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If item 27 is marked othe any injury or other traumatic event, 90ce. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Phillip Dorsey Lelia Moulden 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Lothian, Md. 20711 5186 Sands Rd. William Simms (Husband) 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 11-23-05 Zion Church Lothian, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Wm. Reese & Sons Mortuary,
821 West St. Annapolis, Md. Jarry B. Keese MOO48 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ำ<u>ysician</u> Cardiac 5 minury Medical Due to (or as a consequence of): Examiner o valcular disease Htherosclero h Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day 4□Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been sig Completed 24b. Were autopsy findings available prior to completion of cause of death? clew bitus Sacral has autopsy page performed? Hypertennive Heart ditease 2□ No 2 No certificate 25. Was case relerred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Certification: 28c. Injury at Work? After t 5 Pending investigation 1 ⊠Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 4 - Homicide within 24 hours a To the Funeral D fo the Hospitel 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cai (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D.50653 11-17-2005. SURANA GYAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5851-Deale church ton Road Deale 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			State of Maryland / Department of Health and	•	•	
			1 - State Registrar Certificate of Death		···2005	37253
	ာ		Decedent's Name (First, Middle, Last)	2. Date of Death		3. Time of Death
	Physicia /Medic		Arley Orland Sica, Jr.	November	19 2005	8:35A M
	Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of De	eath	4c. County of Death	
ļ			8738 Endless Ocean Way Columbia		Howard	
	Funeral Director		213-40-2679 (**) 64 Yrs.	lin. 8. Date of Birth (Month, Day, You Oct. 21,	e <i>ar)</i> 9. Birthp Cour 1941 Mar	place (State or Foreign ptry) yland
	and		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			0d. Inside City Limits
	Mary f sho	tor	Maryland Howard Columbia			1 ☐ Yes 2 ☑ No
	r 28a	Director	10e. Street and Number 10f. Zip Code	10g	. Citizen of What Cour	ntry?
	23a c	aiD	8738 Endless Ocean Way 21045		U.S.A	
	tems	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	(Specify Yes or No- lerto Rican, etc.)	14. Race - Americ Black, White,	
0000	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland nartment of Health and Mental Hygiene. ortent: If item 27 is marked other than "naturel", or Items 23a or 28a-f show injury or other treumetic event, the Medical Evantiner must be notified at in.	by	If Yes, Give 1 1 ☐ Yes 2 ☑ No Specify: Year or Dates:		Specify: Wh	nite
ה	"natu	ompleted	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of wife. DO NOT use retired)	working 16	b. Kind of Business/In	dustry
Z	withir ene. then	dmc	Elementary/Secondary (0-12) College (1-4or 5+) Food Service Manager	1	Vending Co	omnany
У <u>5</u>	filed Hygi other	Be Co	To the leave (First Middle Lord)	Name (First, Middle, Mai		эшрану
Jana	Aental Aental rked tic ev	To B	Arley O. Sica, Sr. Hannah	Friend		
Mar	2 sho and I is ma		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or			
í. L	1 and 1ealth 3m 27 ther tr		Evelyn P. Sica (Wife) 8738 Endless Ocean W  20a. Method of Disposition (Name of		a, Maryland	
baltimore,	ages of of the t: ff ite		1 Burial 2 Cremation 3 Removal from State			
	permit. Pages Department of Importent: If i any injury or o					
Ď	permi Depa Impo any ii		21. Signature of Funeral Service Licensee  22. Name and Address of Facility Witzke Funeral Ho 5555 Twin Knotts	me, Inc. Road Colum	bia, Maryl	and 21045
		-1-1	23a. Part 1. Enter the Tsease, or complications that caused the death. Do not enter the mode of dying, such as card shock, or heart failure. List only one cause on each line.			Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	CLR		Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):	-2-31, (1).		-
		Jer	Sequentially list conditions, it any, leading to immediate Dualto (or as a consequence of):			
	cuted nd transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			
,00/	be executed ician and burial-transit	cal Ex	resulting in death) Last Due to (or as a consequence of):			
100	ys e	edica	d			
X	nding use a	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of delive	ery
Ŏ	death	hysician/M	in the past 12 months?  1 Ves 2 No  9 Unknown		Month	Day Year
5	at the	Phys		l oo Bida i		
cords,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burfat-transit	by		1 Tes	co use contribute to th	ably 4 Unknown
) ပ	aw re	ompieted		24a. Was an autopsy		psy findings available inpletion of cause of
ב	slcien: The law certificate has b irector, page 2 s	Com		performed	d? death?	•
N II G	ding Physicien: h. After this certific funeral director,	Be (	Ayaminer/	Death (Check only one)		
5	Physic this cral dire	٦.		g Home 5 N sideno 28d. Describe how		1)
5	ding th. : After fune	tlon	1 Natural 5 Pending (Month, Day Year) Intury Work? 2 Accident investigation M 1 Yes 2 No	25d. Describe now	indary occurred	N N
VISION	Atter er dea ector by the	ertification;	3 Suicide 4 Homicide  1 Homicide  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stree City or Town, S	ot and Number or Rura	l Route Number,
5	ital or irs afte ral Dir led in	0				h
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certilics completely filled in by the funeral director, to	Medical	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and plate	ace, and due to the caus ccurred at the time, date	se(s) and manner as si and place, and due to	ated. the cause(s)
	To the within To the comp	ž			Date signed (Month,	Day, Year)
	/		> 1 licholus Identrelub (Mis D3850)	q N	lovember .	21, 2005
	25		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  NILLUWS KULTICHUSUS 11065 LITTLE PATUXENT P	ky Colum	chia mo	21044
	Sta Registr		31. Date filed (Month, Day, Year) NOV 2 3 2005			

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				State of M	aiyiai		•	ate of Death		Reg. No 20	05	37051
			1. Decedent's Name (First, Middle, La	st)					2. Dete of De	ath	V	3. Time of Death
4	Physicia /Medic		Doylene	Salish	sur	4			Month	Day 18	Zoo5	330
	Examin		4e Facility Name (If not institution, giv			1	0.		r Location of Deeth	4c. County	of Death	1
			vantage the	ouse-54	00 V	anta	ge Your	it Ra Colu	mbia		owar	<u> </u>
	Funeral Director		5. Social Security Number 6. S  426-22-1435  Usual Residence of Decedent	Sex 7. A	ge (In yrs. 84	lest birth	Month	der 1 Year If Under 24 Hr s Days Hours Min		h y, Year) //1921	9. Birthpla Countr Missi	ace (State or Foreign ry) SSippi
	/lend	ŀ	10a. Stete 10b. County		10c. Cit	y, Town	or Location				10	d. Inside City Limits
	Men	ţ	Maryland Howard			Co1	umbia					1 ☐ Yes 2 🗷 No
	th the	ž.	10e. Street and Number				10f. 2	Zip Code		10g. Citizen of	What Countr	y?
	23s	la l	5400 Vantage Poi	nt Road				21044			S.A.	
020	72 hours efter death with the Merylend natural, or items 23s or 28s-1 show ites! Examinet must be motified at	by Funeral Director	11. Merital Status  1 □ Never Merried 2 □ Married  3 ☒ Widowed 4 □ Divorced	12. Wes Decedent Armed Forces  1  Yes 2  If Yes, Give Year or Dates:	?	,S.		edent of Hispanic Origin? ( pecify Cuban, Mexican, Pue 21 No Specify:	(Specify Yes or No- erto Rican, etc.)	14. Rad Blad Specify	ce - America ck, White, et <sup>V:</sup> Whi	tc.
ò	2 hou	<u>8</u>	15. Decedent's E	ducation		16a. C	ecedent's U	sual Occupation		16b. Kind of B		
21215-0020	within ene. then "	Completed	(Specify only highest gra	College (1-4or	5+)	9	Give kind of ife. DO NOT Nurse	vork done during most of w use retired)	orking	Hospit	a1	
pu	be filed tal Hygi d other event,	Bec	17. Father's Name (First, Middle, Lest,						ame (First, Middle,	Maiden Surnan		
Maryland	D & 8 0	2	Leon Shows					Lona	Unknowr	1		
Mar	2 shoul end Mi is meri		19a. Informant's Name/Relationship (					ess (Street and Number or F		-		
	1 end Health im 27 ther t	-	Sandra Reading	(Daughte	-				Alexandi	20c. Location -		
Baltimore,	Peges nent of I int: if ite		1 ☑ Burial 2 ☐ Cremetion 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif					lame of rother plece) eterans Cem.	11-22-		•	
Ħ	permit. P Depertme Importan any injur	-	21. Signature of Funeral Service Licer	/	CH	ertei				Спеттеп	nam, r	Maryland
ñ	Per Jana Per		1/1/1/	1				and Address of Fecility Ke Funeral Ho Twin Knolls		umbio	Morrile	and 21045
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cause	ine deat	h. Do no						Approximate nterval Between
The state of the s	Physician /Medical Examiner	er.	Immediate Cause (Final disease or condition resulting in death)	. M	Due to (c	pl	nsequence	myelo	ng			Onset and Death
Box 68760, <	tificete be ng physicia es the bur	Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. A. d. H	Due to (o	r as a cor	el el nsequence of	2,00				
o.	he de the a	ysic	Part II. Other eignificant conditione c	ontributing to death b	ut not res	ulting in t	he underlying	cause given in Part I.				the cause of death?
<u>α</u>	thet the								. 101	ree 2□No	3 Proba	ibly 4 Unknown
Records,		Completed by							24a. Was a	an autopsy med?	avail	e autopsy findings lable prior to pletion of cause path?
R	The law ete hes page 2	Ē							1 D Y	es 22No	10	Yes 22 No
of Vital	ysician: The is certificete director, pag	Be	25. Was case referred to medical examiner?					26. Place of De	eath (Check only o	ne)		<u> </u>
Ž <	99 10 17	<u> </u>	1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatie		ER/Outp	atient 3		Home 5 ☐ Resid		er (Specify)	Company
on C	tending Phy death. tor: After this	i i	27. Menner of Death  1 ■ Natural 5 □ Pending	28a. Date of Inju (Month, De	y Year)	28b. Tin Inju		28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe h	ow injury occuri	red	
Division	ai or Attending s efter death. I Director: Afte sd in by the fune	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined		ury - At ho c. (Specif	ome, farm			28f. Location (S City or Tow		er or Rural F	Route Number,
	he Hospi in 24 hou he Funeri pletely fill	edical			f examina			d at the time, date and place on, in my opinion, death occ				
	Vithi To th	Σ	29b. Signature end title of certifier				2	9c. License number	-	29d. Date signed	d (Month, Da	ay, Year)
•			When &		5=	5.	u)	1542	7	11/18	3/01	
	10		30. Name end address of person who	completed cause of c	leath (Item	23a) (T	/pe, Print)	16- 441	1.11/	Q' no	NE	MBA
	Stat	0	4/3 Common 31. Date filed (Month, Day, Xear)	saffa f 32. Registr	ar's Signe	ture	ousv	He all	VIIIE	12.60	145	MO11
	Registra		NUV 2 3 200	A Comment	132	do	sole &					

				State of Mandond				-		-	
			1 _ State	State of Maryland		nent of H cate of L			-	11115	37855
	ST 11 %	П	Registrar  1. Decedent's Name (First, Middle, Last)		OCITIII	cate or L		2. Date of De	Reg. No.		3. Time of Death
	Physici /Medic		Lona Elaine	Snyder				Novem	ber	21,200	
	Examir		4a Facility Name (If not institution, give st	reet and number)	Penter 4b.	City, Town, or 6/en	BUM 18	th E	4c.	County of Deal	runde 1
	Funeral Director		213-03-3240	7. Age (In yrs. las		Inder 1 Year nths Days	If Under 24 Hrs Hours Min.		th 17, Year) 2, 191	9. Birt Co	hplace (State or Foreign buntry) MD
	land ow		Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Location	n					10d. Inside City Limits
	the Mary 28e-f sh	Director	Maryland Anne Art	ındel	10	Pas of. Zip Code	adena		10a Citi	zen of What Co	1 ☐ Yes 2 ☑ No
	3a or		8422 Spring Road				1122		rog. Oili.	USA	numry:
	deat	Funerai		Was Decedent Ever in U.S. Armed Forces?	13. Was I	Decedent of Hi	spanic Origin? (S	Specify Yes or No to Rican, etc.)	)-	14. Race - Ame Black, White	
21215-0036	be filed within 72 hours after death with the Maryland at Hygiene. All Hygiene. Activities a constraint or items 23s or 28e-f show event, I're Medical Examinar must be notified at	by	1 Never Married 2 Married 3 XWidowed 4 Divorced	1 □Yes 2 □ No If Yes, Give Year or Dates:		es 2⊠ No	Specify:	to ribari, dic.,			hite
	"natu	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Decedent's	of work done d	luring most of wo	rking	16b. Kir	nd of Business/	Industry
7	filed within 72 Hygiene. other then "na ent, ine Medic	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)		ot use retired, Okeeper			0 1	il Compa	anv
	i Hygi other	Be C	17. Father's Name (First, Middle, Last)			эксорог		me (First, Middle,			
yland	should be nd Mental marked c	To B	John William	Remillieux				Vilson	Clir		
, mar	iges 1 and 2 should it of Health and Men If item 27 le marke or other treumatic		19a. Informant's Name/Relationship (Type Stephen M. Snyder	e, Print) (SON)	19b. Mailing Ad 271 E. (	<sub>dress (Street a</sub> Green S	ind Number or Ri Street, V	ural Route Numbe Vestmins	er, City or ter,	MD 211!	ip Code) 57
saltimore,	Pages 1 ament of He ment of He ant: If item ury or oth		20a. Method of Disposition 1 (X Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)		ce of Disposition netery, crematory stlawn C		1 110 1	Date 26		cation - City or	Town, State Maryland
Baltil	permit. Par Depertmen Important: any Injury once.		21. Signature of Funaral Sarvid, Doens					000			Home, P.A.
-dp			23a. Pan1. Enter the disease, or complete shock, or heart vailure. List only one	entons that caused the death.						,	Approximate Interval Between
	hysician		Immediate Cause (Final disease or condition resulting in death)		scula	A	cciden	<b>L</b>			Onset and Death
	/Medical Examiner	Ĭ	resulting in dealth)	Due to (or as a consequer	nce of):						
P		Jer	Sequentially list conditions, b. cause. Enter Underlying Cause (Disease or injury that initiated events c.	Due to (or as a sponsequer	nne of)-						
	be executed cien and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last								
	be exe	cal Ex		Due to (or as a consequer	nce at):						
200	certificate iding phys		d.						т.		
Š	th cert tending r use a	an/M	230. Was decedent pregnant	c. If yes, outcome of pregnance		DIC pregnancy			2	3d. Date of deli	very
	the death by the atter ached for u	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of deat 9□ Unknown	=	or (specify)				Month	Day Year
ds, r	law requires that the death certificate be executed es been signed by the attending physicien and 2 should be detached for use as the burial-transit	þ	Part II. Other significant conditions cont	ributing to death but not resulting	ng in the underly	ring cause give	n in Part I.				the cause of death?
ecords,	s been s been s shou	ojete						24a. Was			
	90 4	Completed						autop perfo 1 ☐ Yes	rmed? 2 No	death?	topsy findings available completion of cause of 2 No
\ [a	erctar s certil	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	ospital:	VOutpatient 3[	Othe		ath Check only o		(Tau (a	
5	ig Phy ler thii neral c	n: T	27. Manner of Death		Bb. Time of Injury	28c. Injury Work	at	lome 5 Resident			ury)
Sion	endin eath. or: Aff	atio	1 Vatural 5 Pending 2 Accident investigation		М	1 🗆 Y	es 2□No				
	To the Hospital or Attending Physician: The within 24 hours effer death.  To the Funerel Director: After this certificate completely filled in by the funeral director. par	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, street, fa	actory, office		28f. Location (S City or Tow	Street and vn. State)	Number or Ru	ral Route Number,
	Tospii 4 hour Tuner ely filli	edicai	(Chack only 2   Medical Examine	cian: To the best of my knowle	edge, death occu	irred at the time	e, date and place	, and due to the	cause(s) a	and manner as	stated.
	thin 2 the o the o	Med	one)  29b. Signature and title of certifier	and manner stated.		29c. License				signed (Month	
1	F 3 F 8			sahun M.							
	in		30. Name and address of person who com		3a) (Type, Print)	2007	1773	^	rurei	aber o	0904
	10			500 Sutherlan	nd hil	1 Way	Silves	e sprine	9 2	MD 2	0904
	Sta Registr	-	31. Date filed (Month, Day, Year) NOV 2 3 2005	2. Registrar's Signature	Sporte	8					

–0 <i>i</i> n	841		5or	State o	f Maryland / D								ata anne ath I	
		4	1- For Unpend Iter	n 23a,pt.I	I,27,28a-f	Cert	iffeate 6859	beath	L3-05	tas	Reg. No. 0	15	378	56
3	Physici	an	1. Decedent's Name (First, Midd.	le, Last)						2. Date of De.	ath Day	_Year_	3. Time of	
4	/Medic		Christopher		Gus		Sikalis			Novemb	er 20,		6:11	Рм
	Examir	er	4a. Facility Name (If not institution University of M				4b. City, Town, or Baltimo				N	y of Death		
2	Funeral		5. Social Security Number	6. Sex 1 <b>X</b> M 2 ☐ F	7. Age (In yrs. last birth	hday)_ 'rs.	If Under 1 Year Months Days	If Under :	24 Hrs. Min.	8. Date of Birt (Month, Da	h y, Year)	Cou	place (State o	r Foreign
	Director		217-02-0627 Usual Residence of Decedent		26 Y					December	9, 1978	Mar	yland	
	72 hours after deeth with the Maryland natural', or Hems 23e or 28e-f show Jical Examinat nature notilited at	7	10a. State 10b. County		10c. City, Town	_						1	0d. Inside Ci	
	s 1 and 2 should be filed within 72 hours after deeth with the Marylar if Health and Mental Hygiene. Item 27 Is marked other than "natural", or Items 23e or 28e-f show other traumatic event, tre Medical Exartinal must be notified at	by Funeral Director	MD Hari	ora	Abir	igac	10f. Zip Code				10g. Citizen of	What Cou		2 <b>A</b> 140
	3e or		627 Nanticoke (	Court			21009	ı			USA	Wilat Cou	, .	
	deeth	nera	11. Marital Status		edent Ever in U.S.	13. W	/as Decedent of Hi Yes, specify Cuba		gin? (Spe	cify Yes or No		ce - Ameri		
98	or Ite	y Fu	1 Never Married 2 Mar	ned 1 ☐ Yes tf Yes, Giv	2 <b>X</b> No ∕e		Tes, specify Cuba. ☐ Yes 2√∑ No	Specify:	i, Fuelto r	nicari, etc.)	Speci	ck, White,		
215-0036	'72 hours after dee "natural", or Items idical Exeminat m	q pa	3 ☐ Widowed 4 ☐ Divorced	Year or D	ates:		ent's Usual Occupa				16b. Kind of E	MIIT		
215	in 72 in "na Medic	Completed	(Specify only higher Elementary/Secondary (0-12)	est grade completed)  College (1		(Give k	and of work done of NOT use retired,	lurina mosi	t of workir	ng	TOD. KING OF E	0051110557111	dustry	
212	od within giene. er then *	E O	12 years	College (		ne I	mproveme	nt Co	ontra	ctor	Constr	uctio	n	
pu	be file tal Hy d oth	Be	17. Father's Name (First, Middle,							,	Maiden Sumai	,		
Maryland	should be filed within ind Mental Hygiene " s marked other than " umatic event, the Max	ဥ	Gus John Sikal:		105	\$ 4 = 20 = -	Add (C)				Phillip		0:11	
Ma	id 2 sho lith and 27 Is m		19a. Informant's Name/Relations Tiffany Lynn S:			_	Address (Street a anticoke						1009	
6	s 1 ar f Hea item		20a. Method of Disposition		20b. Place of	Disposi			vovem		20c. Location			
Ë	Page nent o ant: If ary or		1 ☐ Burial 2 X Cremation 4 ☐ Donation 5 ☐ Other (5				rematory			2005	Baltim	ore,	MD.	
Baltimore,	permit. Pages 1 and 2: Department of Health ar Important: If item 27 is eny injury or other trau		21. Signature of Funeral Service	(dt)	Connelle	22 71	Name and Address Onnelly F 110 Solle	s of Facility unera ers Po	al Ho	me Of I Road, I	Dundalk Dundalk	P.A.	21222	
	* *		23a. Part 1. Enter the disease o shock, or heart failure. List	r complications that of	aused the death. Done	t enter	r the mode of dying	g, such as	cardiac o	respiratory ar	rest,		Approximate Interval Bets	ween
1	Physician		Immediate Cause (Final disease or condition		Force Neck								Onset and [	Death
	/Medical Examiner		resulting in death)	Due to	(or as a consequence o	f):								
*		er	Sequentially list conditions, if any, leading to immediate	b. Due to	(or as a consequence of	f):								
	outed id ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	<b>S</b> .										
0,	be executed icien and burial-transit	Exa	resulting in death) Last	Due to	or as a consequence of	f):								
8760,	cate by	dical		d										
89 X	certific Iding p	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	come of pregnancy						22d D	ite of delive	201	
Box	es that the death certificate be executed igned by the attending physicien and be detached for use as the burial-transit	Physician/Med	in the past 12 months?	4 ☐ Pregn	wirth 2 Fetal death pant at time of death		Ectopic pregnancy Other (specify)					onth	,	/ear
P.0	at Ihe I by th	hys	9 🗆 Unknown	9□ Unkno										
	The law requires that the death certifica ete has been signed by the attending phage 2 should be detached for use as the	l by	Part II. Other significant conditi Gunshot Wounds		_	the und	derlying cause give	n in Part I.		23e. Did to	bacco use con		ne cause of d lably 4 □L	
Records,	w requir been si should I	lete								24a. Was			psy findings a	
	The la te has age 2	Completed by								autop	rmed?	prior to co death?	mpletion of ca	ause of
ital	itan: artifice ctor, p	Bec	25. Was case referred to medica examiner?	ıl				26. Place	of Death	(Check only o	2 No   ne)	1,25(105	2 140	
of V	Physician: this certifice ral director, I	ို	1 AYes 2 No		npatient 2 ER/Out			4 🗆 1901			lence 6 🗆 Ott			_
Division of Vital	ding F	lon	27. Manner of Death  1 Natural 5 Pendii		h, Day Year) Foun	ive!	28c. Injury Work 1 □ \	at :? ∕es 2. <b>∑</b> /1	1	8d. Describe h	low injury occur	red	un	k
/isi	Attending r death. ector: After by the funer	fica	3 Suicide 6 Could	not be 28e. Place	0-05 4:30 of Injury - At home, fare			- X		8f. Location (S	treet and Num	per or Rura	l Route Num	ber <sub>a</sub>
Ö	s after s after sel Dire	Certification:	4  Homicide	Scene	ng, etc. (Specify)				J	oppator	Street and Number, State) / [ wne , Md	/ Sin	ger Ko	ad
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificete has completely filled in by the funeral director, page 2.	Medical (	29a. Certifier 1 Certifyii (Check only one) 2 Medical	Examiner: On the ba	best of my knowledge, asis of examination and ner stated.	death (	occurred at the timestigation, in my op	e, date and pinion, deat	d place, a th occurre	nd due to the o	cause(s) and m date and place,	anner as s	ated. the cause(s	)
	To the within To the comp	M	29b. Signature and title of certifie	)r			29c. License				29d. Date signe			
•			· met	4.			0.0	C.M.E.	•		Novembe:	r 21,	2005	
_			30. Name and address of person	who completed caus	, , ,		rint) Penn Str	eet,	Balt	imore,	Maryla	nd 21	201	
	Sta Registr		31. Date filed (Month, Day, Year, NOV 2 3	and the second	egistrar's Signature	Son	us.							
100	34 mm m		IAO A SO	Jak	Figure 1	The Real Property lies								

		•	1 - For Amend Item :	State of Marylar 26 per verb.,	nd / Departme C849 Prifica	nt of Health and 105dhb lie of Death	Mental Hygie	ne 2005	37857
	Physici /Medic		1. Decedent's Name (First, Middle, Last)		AVICK		2. Date of Death Month	Day Year 2 Uns	3. Time of Death 2:36 AM
1	Examin		4a. Facility Name (If not institution, give s	sex Rd.	(	y, Town, or Location of Dec		4c. County of Death	imore
	Funeral Director	4	5. Social Security Number 6. Sex 2/6-30-2375 Dusual Residence of Decedent	M 2 F 7. Age (In vrs.	Yrs. If Und	er 1 Year If Under 24 Hi s Days Hours Mi		9. Birth 1920 L.1 T	place (State or Foreign ntry) huania
	a-f ehow	ctor	10a. State 10b. County	10c. Cit	ty, Town or Location	Battin	rare		10d. Inside City Limits 1 XYes 2 □ No
	ath with the 23s or 28	rai Director	10e. Street and Number 809 60	rsuch A	101. Z	21218	) 10g.	Citizen of What Cou	ntry? A
920	urs atter des el', or Iteme	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	2. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	If Yes, sp	edent of Hispanic Origin? eacify Cuban, Mexican, Pue 220 No Specify:	Specify Yes or No- erto Rican, etc.)	14. Race - Ameri Black, White, Specify:	
21215-003	be filed within 72 hours after death with the Maryland all Hygiene.  Isl Hygiene.  of other then "netural", or iteme 23a or 28a-f ehow other then "netural", or iteme and other then hadical Examinar must be notified at	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	College, (1-4or 5+)	ilite. DO NOT	vork done during most of w	orking	Kind of Business/Ir Copper	
Maryland 2		To Be C	17. Father's Name (First, Middle, Last)		unKna	18. Mother's N	ame (First, Middle, Mai	den Sumame)	unKnun
	1 and 2 s Health ar em 27 le		19a. Informant's Name/Relationship (Typ.  Jane Saw v C K  20a. Method of Disposition  1 € Burial 2 □ Cremation 3 □ Re	as-daughter	Can A	ss (Street and Number or I	Backs 1	ity or Town, State, Zij MG · Z   Z   c. Location - City or To	8 Floor
Baltimore,	permit. Pages Department of Importent: If It eny Injury or o		4 Donation 5 Other (Specify)  21. Signature of Tue ral Servic Lightness	1 46	OUTON YAY 22. Name :	and Address of Facility	1505 P	n Timpra uss ne Baeto	MP 21229
	Physician		23a. Part I. Enter the disease, or compile shock, or near failure. List only on Immediate Cause (Final disease or condition	cations that caused the deat e cause on each line.	th. Do not enter the mo	ode of dying, such as cardi	ac or respiratory arrest,	)555,0	Approximate Interval Between Onset and Death
	/Medical Examiner	Examiner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		ayence of):	, /			
8760,	icate be executed physicien and s the burial-transit	dicai	resulting in death) Last	Due to (or as a conseq	quence of):				
O. Box 6	death certit e attending id for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	Bc. If yes, outcome of pregnation 1 Live birth 2 Feta 4 Pregnant at time of c	al death 3 Ectopic			23d. Date of deliver Month	ery Day Year
rds, P.	The law requires that the te has been signed by th rage 2 should be detache	by	Part II. Other significant conditions con	tributing to death but not res	sulting in the underlying	cause given in Part I.	23e. Did tobac	co use contribute to t	he cause of death?
Vital Records,		Completed					24a. Was an autopsy performed 1 ☐ Yes 2 ☑	prior to co death?	opsy findings available impletion of cause of 2 No
Division of Vit	ding Phys h. Alter this funeral di	ation: To Be	25. Was case referred to medical examiner?  1  Yes 2 No H  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	ospital: 1 Inpatient 2 Inpatie	28b. Time of Injury	Other	Home 51 Hesidence 28d. Describe how i	e 6 ∐Other (Specil	ssisted Living
DIVIS	를 를 드	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, street, factory)	ory, office	28f. Location (Stree City or Town, S	t and Number or Rura tate)	al Route Number,
	To the Hospital or At within 24 hours after or To the Funeral Direct completely tilled in by	Medicai	(Check only 2 Medical Examin	ician: To the best of my known: On the basis of examina and manner stated.	ation and/or investigation	on, in my opinion, death oc	curred at the time, date	and place, and due to	the cause(s)
	(2)		29b. Signafure and title of certifier	Keololy	4	9c. License number	f N	Date signed (Month,	2005
	(0)		30. Name and address of person who con  2   Velucio  31. Date filed (Month, Day, Year)	mplated cause of death (lifer	Srite 3	12 BOK	timore 1	102120	1
	Sta Registr		NOV 2 3 2005		Consider				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Deeth 1. Decedent's Name (First, Middle, Last) Dey Month Year Physician 19, 2005 November 1:55 AM Stewart Woodrow Annie /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street end number) 4c. County of Deeth Examiner Harford 1408 Pomroy Avenue Abingdon If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthdey) **Funeral** Days Hours Months 1 ☐ M 2 🗓 F Yrs. Director 4, 1924 West Virginia 236-36-1795 Usuel Residence of Decedent permit. Pages 1 end 2 should be filed within 72 hours efter death with the Marylend Depertment of Health end Mental Hygiene. Important: If them 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event. It a Marties Ferral Control of the 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. Stete 1 ☐ Yes 2 ☐ No Funeral Director Maryland Harford Abingdon 10g. Citizen of Whet Country? 10f. Zip Code 10e. Street end Number USA 21009 1408 Pomroy Avenue 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Maritel Status 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify. Specify Completed by 3 Widowed 4 □ Divorced Year or Detes: White 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Dry Cleaners Laundry Attendant 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Carrie u/k Smoots u/k Gardner Lloyd 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1408 Pomroy Ave., Abingdon, Maryland 21009 Sharon L. Bradford - Daughter 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place) 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Zion U.M. Church Cem 11/21/05 Bel Air, Maryland 4 ☐ Donation 5 ☐ Other (Specify) McComas Funeral Home, F.A. 22. Name and Address of Facility 21. Signature Funeral Service Licensee 1317 Cokesbury Road, Abingdon, Maryland 21009 Perf . En er the disease, or complica institute a caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart tailure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediete Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Physician/Medical Examine use as the buriel-trensit or Attanding Physician: The law requiras that the death certificate be axecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Lest Due to (or as e consequence of): Division of Vital Records, P.O. Box 68760, Aftar this cartificate has been signed by the attending physicien funeral diractor, page 2 should be detached for use es the burie Due to (or es a consequence of): 23b. Did tobecco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 Probably 4 Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1 ☐ Yes 2 No 1 □ Yes 2 □ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No Medical Certification: To 28c. Injury at Work? Manner of Death 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred filled in by the funer 1 Natural 2 ☐ Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No death. 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Hospital within 24 hours To the Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicat Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner steted. 29c. License number 29d. Date signed (Month, Day, Yeer) 29b. Signature end title of certifie 36246 wwe 30. Name end address of person who completed cause of death (Item 23e) (Type, Print) Burnie MD 21060 Koeslei len 31. Date filed (Month, Day, Year) 32 Registrer's Signature State 2005

Registrar

			State of Maryla	nd / Depa	rtment of	Health and	Mental Hy		)5 3	37859
		Decedent's Name (First, Middle, Las	<i>(†</i> )	0071		Dodin	2. Dete of D	Reg. No.		3. Time of Death
	Physician		•				Month	Dey	Yeer	_
	/Medical	Miriam Rebecc  4a Fecility Neme (If not institution, give				4b. City. Town, or	Location of Dee		of Deeth	8:00 P
1	Examiner		street end number)							
		LORIEN  5. Social Security Number 6. Se	7 Age (In urs	: lest birthday)	If Under 1 Year	BEL F	1 R 8. Date of B		KORI	
	Funeral Director		TM 2DE		Months Deys		. (Month, D	ey, Yeer)	Counti	ace (State or Foreign
৬		Usuel Residence of Decedent	9	2			NOV.	14, 1913	Penn	sylvania
1	M 1	10a. State 10b. County	10c. C	ity, Town or Loc	ation				10	d. Inside City Limits
3	to Fig.	Maryland Baltimo	ro K	ingsvil	1.0					1 ☐ Yes 2√€ No
4	23a or 28a-f ehow unt be notified at rai Director	10e. Street end Number	IC I	IIIGSVII.	10f. Zip Code			10g. Citizen of	What Countr	y?
3	D E	11711 Bellvue Av	e.		210	087		US	: A	
-	r tems 23 diner must Funeral	11. Merital Status	12. Was Decedent Ever in t	U,S. 13. W	as Decedent of	Hispanic Origin? (S	Specify Yes or N	o- 14. Ra	e - America	
0		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No			oan, Mexican, Puèr	to Hican, etc.)		ck, White, et	tc.
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27	lygiana.  Nor than "natura  It, the Medical E		3	Regis	tered Nu			Health		
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S ADD 1 NG 7- 9020 Maryland 21215-9020	marked o	George H. Kuntz				Jennie	(nmn)	Ressle	r	
Mar	D E E	19a. Informent's Name/Reletionship (7		19b. Mailing	Address (Stree	t end Number or R	u <i>rel Rou</i> te Numi	oer, City or Town	State, Zip C	Code)
	Haalth em 27 ither tr	Elizabeth S. Moore				Way, Jopp	a, Mary	land 210	85	
		20a. Method of Disposition  15€ Buriel 2 ☐ Cremation 3 ☐		Plece of Disposi cemetery, creme	ition (Name of etory or other ple	oce)	Date	20c. Location	City or Tow	m, State
H m	nent Int: I	4 Donation 5 Other (Specify	Be.	l Air Me	emorial	Gardens	11-28-0	Bel A	ir, Ma	aryland
Baltimore,	Department of important: If is any injury or page.	21. Signature of Funeral Service Licens	500	22 Ma	Name and Addr	ess of Facility Uneral H	omo D 7	\		
MIRIAM Baltimore		Steller (1	Rusely			sbury Ro			arvil ar	21009
	-	23a. Pert1. Ent. the diseese, or comp	lications thet a used the dee							Approximate
P	hysician	shock, or heart failure. List only o	one cause on eech line.							nterval Between Onset and Death
	/Medical	Immediate Ceuse (Finat disease or condition	ENDETAC.	c hea	AGNITI'S	1 417	HEIMER	1º	1	
	xaminer	resulting in death)	a. ENDSTAGE	or as a consequ		, MLC	7 C IIIC I	7		
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89	es the	resulting in death) cast							i	
. Box 6	artificate hes been signed by the ettending protor, page 2 should be deteched for use es Be Completed by Physician/Mer		d						1	
П д	ed fo	Part It. Other significant conditions co	ntributing to death but not re-	sulting in the und	derlying cause gi	ven in Part I.	23b. Did	tobacco use co	ntribute to t	he cause of death?
I Records, P.O	by th	Nings-come	`	252 54	/ .		10	Yes 3 No	3 ☐ Proba	bly 4 Unknown
S, S	pe de de de de de de de de de de de de de	DIABETES ME		PERTER	Sion					
p.c	baan si should	COROMARY ARTE	201/2/22/22				24a. Was	an eutopsy ormed?	24b. Were avail	e autopsy findings able prior to
	s baan 2 should pletec	COROMARY ARTE	RY DISEASE						com	pletion of cause ath?
~ ž	ta he age						10	Yes 200 No	10	Yes 2□ No
<u>a</u>	tor, p	25. Was case referred to medical				26. Place of De	ath (Check only	one)	1	
Division of Vital Records, P.O	direction of the contraction of	examiner? 1 ☐ Yes 2 █ No	Hospitel: 1 ☐ Inpatient 2 ☐	ER/Outpatient	3□ DOA Ot	her: 4 Nursing I	lome 5□ Res	dence 6 □Oth	er (Specify)	
0 4	arth heral	27. Menner of Death 1. Netural 5 □ Pending	28e. Dete of Injury (Month, Dey Year)	28b. Time of Injury	28c. Inju			how injury occur		
Division	r: Aft re fur atlo	1. Netural 5 ☐ Pending 2 ☐ Accident investigation	(	,,		Yes 2 □ No				
Vis	ecto ecto by th	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, stree	et, factory, office		28f. Location (	Street and Numb wn, Stete)	er or Rurel I	Route Number,
Ö	Cer of Dir		saliding, old. (open	-77			2.17 0. 10	,,		
I To the Hospital	within 24 hours efter death.  To the Funerei Director: After this certificate hes complately filled in by the funeral director, page 2.  Medical Certification: To Be Comp	29a. Certifier to Certifying Phy	sician: To the best of my knoiner: On the besis of examine	owledge, death o	occurred at the ti	me, date and place	e, end due to the	cause(s) and ma	anner es stat	led.
2	in 24 the F tplate	one)	end menner stated.	anwor nive			ou at tire time,			```
- 6	To the	29b. Signeture and title of certifier			29c. Licen			29d. Date signe	d (Month, De	ey, Yeer)
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DHMH 16 Rev 6/95

State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Day
NOVEMBER 21, **Physician** JOSEPH SACCA 2005 10:10A<sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 109 SUNSHINE COURT FOREST HILL HARFORD If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months 1 X M 2 □ F 215-22-5552 77 Yrs. Director PENNSYLVANIA 3-2-1928 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Modical Examination must be notified at MD HARFORD FOREST HILL Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 109 SUNSHINE COURT 21050 U.S.A. APT. A Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Il Yes, Give Year or Dates: WWII Specify: Be Completed by WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) BARBER SELF EMPLOYED 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fil ment of Health and Mental H ant: If Item 27 Is marked ott PAUL SACCA LUCIA (PIRRUCCELLO) 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 109 SUNSHINE COURT APT A SOPHIA SACCA / WIFE FOREST HILL, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 6 permit. Page Department of Important: If any injury or once. GARDENS OF FAITH CEM 11-25-05 \* 4 □ Donation 5X Other (Specify) ENTOMEMENT BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVENUE ROSEDALE, MD 21237 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CARDIOPULMONARY /Medical Examiner 4 months LUNG CANCER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Completed by Physician/Medical as the esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐ Yes 2 No detached the 9 Unknown 9 Hinknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔊 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed this certificate 2 **X**No 2 🗌 No 1 ☐ Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Nesidence 6 Other (Specify)

Injury at 28d. Describe how injury occurred 2 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: Director: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29d. Date signed (Month, Day, Year) 29b. Sidh 29c. License number 00 m Ó Greet Baltimare (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) Registrar's Signature State 3 Registrar

Anthony W. Stephens Jr. Please Type or Print in Black Indelible ink. Ensure All Copies Are Legible. Amend/Unpend item#23a, 2/,28a-f, perME, G850, 12-16-05 TI State of Maryland / Department of Health and Mental Hygiene 05 - 7833ALG 1 - For State Registrer Reg. No. Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** William Anthony Stephens, Jr. 2:18 P M November 20, 2005 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 7884 Harold Road Baltimore County Dundalk If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sax 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 ★M 2 ☐ F Yrs. 36 Director 218-06-6772 Dec. 7,1968 Maryland Usual Residence of Decedent Maryland 10c. City, Town or Location r 28a-f ehow 10a State 10b. County 10d. Inside City Limits 1 ☐ Yes 257No Director Dundalk Maryland Baltimore the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Examiner must be 21222 7884 Harold Road United States death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ZXNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 end 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 ie marked other then "neturei", or item eny injury or other traumatic event, the Medical Exemples 2008. Black, White, elc. Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Flementary/Secondary (0-12) College (1-4or 5+) Construction Worker Construction 12 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jean Marie Garrett William A. Stephens, Sr. 2 19a. Informant's Name/Relationship (Type, Print) Fall er 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. William A. Stephens, Sr. 7884 Harold Road Dundalk, Maryland 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 🖫 Cremation 3 ☐ Removal from State Hilltop Service Corp. 11/25/2005 Towson, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Juda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Methadone Intoxication disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, I any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner anding physicien and use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Month 4□Pregnant at time of death 5 Other (specify) ed by the a detached f P.O. 9 Unknown s been signed be should be deta Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ② Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ★ Yes 2 □ No 24a. Was an autopsy performed? page 2 certificete 1 Yes 2 No the Hospital or Attending Physician; After this certific funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other:  $_{4\,\square}$  Nursing Home  $_{5\,\square}$  Residence  $_{6\,\square}$  Other (Specify) at SCENE Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA ٩ 1XXes 2 No 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred unk 28a. Date of Injury Rb. Time of Fnd Month, Day Year) Fnd Injury Certification: 1 Natural 5 Pending death. investigation 1 ☐ Yes 2x XVo 2 Accident 2:10 P the 11-20-05 Director 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 7884 Harold Rd. 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ۵ 4 Homicide hours after Illed in n 24 hou. the Funeral D Scene Dundalk, MD 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2X Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 2 Messa November 21, 2005 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year)

NOV 2 3

2005

111 Penn Street, Baltimore, Maryland 21201

RUBIO, MD

32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

NOV 2

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 37863 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Year Kenneth Eugene Sutton /Medical 11 16 2005 11:30 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 658 Kennebec Avenue Takoma Park Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 1 3 M 2 □ F Director 549-76-8957 6-21-1948 California Usual Residence of Decedent deeth with the Maryland 10a. State r then "naturel", or items 23a or 28a-f show the Medical Examinar must be notified at 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Ves 2 No Montgomery Takoma Park 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 658 Kennebec Avenue Funeral 20912 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, filed within 72 hours after Black White etc 1 ☐ Never Married 2 ☑ Married 1 ☆Yes 2 □ No If Yes, Give Year or Dates: Maryland 21215-0036 þ 1 ☐ Yes 2 ➡ No Specify: 3 Widowed 4 Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Nurse Medical treumatic event, 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill thent of Health and Mental H tent: If item 27 is marked oth jury or other treumatic even Be 18. Mother's Name (First, Middle, Maiden Surname) ٥ Elmer Sutton Barbara Sutton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alice Sutton/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)

Ave. Takoma park, MD 20912

20c. Location - City Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or once. <sup>1</sup> 4 □ Donation <sup>2</sup> 5 □ Other (Specify) Chesapeake Crematory 11-18-2005 Beltsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Silver Spring, MD 20910 mo1358 Rapp Funeral & Cremation Service 933 Gist Ave. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Metastatic Lung Cancer disease or condition resulting in death) 20 months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Liceace or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospitel or Attending Physicien: The law requires that the death certificate be executed and Due to (or as a consequence of): Box 68760. attending physicien Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month 4☐Pregnant at time of death 5 Other (specify) Day Year P.0. detached 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ģ Completed ty⊒Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1□ Yes 2√2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner 1 ☐ Yes 2 ☐ No Hospital: 2 Other: 1 Inpatient 2 EP/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury Certification: 28c. Injury at Work? 28d. Describe how injury occurred After 1 √ Natural 2 ☐ Accident 5 Pendina death investigation 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 🗌 Suicide 28e. Płace of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide in 24 hours. the Funerel Dire TEXCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check on one) 2 Medical Exa To the within 2 To the 29b. Signat 29c. License number 29d. Date signed (Month, Day, Year) D08754 Nov. 17, 2005 completed cause of death (Item 23a) (Type, Print) Thomas A. Ben inger, MD 7525 Greenway Ctr. Dr. Greenbelt, MD 20720 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2005

			1 - For State Registrar	State of M	aryland / Dep Ce	ertificate of			iene 9. No. 005	37864
	Physic	ian	Decedent's Name (First, Middle, Li					2. Date of Deat Month	h Day Yea	3. Time of Death
	/Med Exami	cal	Dorothy Claire  4a. Facility Name (If not institution, gi  Bedford Court N	ive street and number)			or Location of Death	11	15 200 4c. County of D	5 02:30 n
	Funeral Director		5. Social Security Number 6. 137–14–6834		ge (In yrs. last birthday 82 Yrs.		r If Under 24 Hrs.	8. Date of Birth (Month, Day, 03–31–1	Year) 9. I	Birthplace (State or Foreign Country) ennsylvania
	ne Maryland 8e-f show	ector		tgomery	10c. City, Town or L	ocation Spring				10d. Inside City Limits 1 ☐ Yes ঽ∑tNo
	3a or 2	i Dire	10e. Street and Number 14652 Kelmscot	Dr.		10f. Zip Code	20906	10	ng. Citizen of What USA	Country?
9036	filed within 72 hours after death with the Maryland Hygiene. ther than "naturel", or Items 23a or 28e-f show this the Medical Exantiest must be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 ☑ No	Hispanic Origin? (Sp ban, Mexican, Puerto	pecify Yes or No- Rican, etc.)		
215-(	within 72 h ene. than "natu ne Madica	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation a de completed) College (1-4or :	(Give 5+)	DO NOT use retir	e during most of work	sing	6b. Kind of Busine	•
and 21	d la la	Be	12 17. Father's Name (First, Middle, Last Earl Robbins	t)	Но	memaker		e (First, Middle, M	,	ome
Mary	& B E E	2	19a. Informant's Name/Relationship Dana Martin/dau	, ,, ,	19b. Mail 735	ing Address (Stree	et and Number or Rur ove Dr. Ro	al Route Number,	City or Town, State	e, Zip Code)
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other trai once.		20a. Method of Disposition 1 ☐ Burial 2 ত Cremation 3 ☐ 1 ⁴ ☐ Donation 5 ☐ Other (Speci			osition (Name of matory or other pl ake Crem	ace)	Date 2	Oc. Location · City Beltsvil	
Balti	permit. Departm Importa any Inju		21. Signature of Funeral Service Lice	7 -		2. Name and Addi Rapp Fu		emation	Service	
	Pnysician /Medical Examiner		23a. Part1. Enter the disease, or come shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	a. Lun Due to (or as	Cancer a consequence of):	ter the mode of dy	ing, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death
À.	cate be executed physician and the burial-transit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Lister of the International Cause Ca	c	a consequence of): a consequence of):					
68760,	death certificate be executed e attending physician and id for use as the burial-transit	dicai	l	d			***************************************			
.O. Box	the first	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes > → No 9 ☐ Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant at 9□Unknown	2 Fetal death 3	□Ectopic pregnanc □ Other (specify)	су		23d. Date of d Month	lelivery Day Year
ords, P.		þ	Part II. Other significant conditions of	contributing to death b	ut not resulting in the u	nderlying cause g	ven in Part I.	11		to the cause of death?  Probably 4 Munknown
al Records,	The lar ate has page 2	Completed						24a. Was an autopsy performe	prior to	
Vital	Physician: rthis certificant	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatie	at 2□ED/0	ot ot	haa	(Check only one)		
Division of	ding After fune	ation: To	27. Manner of Death  1  Natural 5  Pending 2  Accident investigation	28a. Date of Injui (Month, Day		f 28c. Inju	4X Inursing Ho	me 5 ☐ Residen 28d. Describe how	ce 6 Other (Sp	ecify)
Divis	in the	Certification:	3 Suicide 6 Could not b		ury - At home, farm, sti c. (Specify)	eet, factory, office		28f. Location (Stre City or Town,	et and Number or F State)	Rural Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medical	one) 2 medical Exar	nysicien: To the best of niner: On the basis of and manner sta	examination and/or in	n occurred at the ti vestigation, in my	me, date and place, a opinion, death occurre	and due to the cau ed at the time, date	se(s) and manner a e and place, and du	as stated. ue to the cause(s)
		2	29b. Signature and title of certifier	8/001		29c. Licen	D50545	290	1. Date signed (Mor	
	Sta	*0	30. Name an address of person who Godswill O. Oko 31. Date filed (Month, Day, Year)	ji 7513 Nev	w Hampshir	•	oma Park M	D 20912		
	Pariet	0.0		105 Harrisa	, N. AD	July Con				

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3	Physici		1. Decedent's Name (First, Middle, Las. Willis Lee Shafe	•					Date of Dear Month	Day	OO5	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, give Holy Cross Hospi	street and number,	l	4b. City, Town	or Location o			4c. County		1
*	Funeral Director		505-20-5935	x 7. Aq	ge (In yrs. last birthda) 81 Yrs.	/) If Under 1 Ye. Months Day		Min.	Date of Birth Month, Day, 1-19-1	Year)		place (State or Foreign intry) braska
	Maryland B-f show	tor	Usual Residence of Decedent	mery	10c. City, Town or I					<u> </u>		10d. Inside City Limits 1X Yes 2 □ No
	h with the	Funeral Director	10e. Sireet and Number 32 Hickory Av			10f. Zip Code	2091	2	1	0g. Citizen of V USA	What Cou	intry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Itam 27 is marked other than "natural", or items 23e or 28e-1 show any Injury or other traumatic avant, the Medical Examinar must be neithed at Once.	b	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Armed Forces' 1 ☑ Yes 2 ☐ If Yes, Give Year or Dates:	Ever in U.S. 13	. Was Decedent of If Yes, specify C			Yes or No- n, etc.)		k, White	can Indian, , etc. ite
Maryland 21215-0036	within 72 ho lene. then "natur the Wedical I	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	cation le completed) College (1-4or	(Giv life.	edent's Usual Occ e kind of work don DO NOT use ret municati	ne during mosi ired)	t of working		16b. Kind of Bu		epartment
land	ild be filed lental Hyg ked othar ilc avant,	To Be C	17. Father's Name (First, Middle, Last)  Max U. Shafer					a A. Pa		Maiden Surnam 1	10)	
	ind 2 shou alth and M 27 le mai or traumai	-	19a. Informant's Name/Relationship (7) Willis Lee Shafe		19b. Mai	ling Address (Stre Hickory	et and Numbe Ave Ta	er or Rural Ro .koma P	ute Number ark MI	c, City or Town, 20912	State, Zi	p Code)
Baltimore,	Pages 1 annent of Hermant: If Itam		20a. Method of Disposition  1 Burial 2 Cremation 3 4 Donation 5 Other (Specify,			oosition (Name of ematory or other p eake Cress		Date 11-23-		20c. Location - Belts		
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Vital Records,		Completed							24a. Was a autops perforn 1 □ Yes 2	ned?	Were auto prior to co death?	opsy findings available ompletion of cause of
f Vita	ding Physician: The I h. After this certificate ha funeral director, page	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1 ⊋Inpati	ent 2 ☐ ER/Outpati	ent 3 DOA	)thor	of Death (Ch Irsing Home		e) ence 6 🗆 Othe	er (Speci	<b>(</b> Y)
Division of	Attending Physician: r death. actor: After this certific by the funeral director,		27. Manner of Death  1 Natural 5 Pending investigation	28a. Date of Inji (Month, Da	ury 28b. Time Injury	V	jury al Jork? Yes 2 1		Describe ho	ow injury occurr	ed	
DİXİ		Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of In building, e	jury - At home, farm, s tc. <i>(Specify)</i>	treet, factory, offic	<b>⇔</b>		Location (St. City or Town		er or Run	al Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir. completely filled in I	edical	29a. Certifier Certifying Phy (Check only one)	rsician: To the best iner: On the basis of and manner si	of my knowledge, dea of examination and/or lated.	ath occurred at the investigation, in m	time, date an y opinion, dea	d place, and o th occurred at	due to the ca t the time, da	ause(s) and ma ate and place, a	nner as s and due t	stated, o the cause(s)
)	To the P within 24 To the F complete	Σ	29b. Signalure and title of certifier	R	12		633	43	21	9d. Date signed	(Month.	Day, Year)
	10+1		30. Name and address of person who carrina Y. Ruban				Sprin	g MD 20	0910			
	Sta Registr		31. Date filed (Month, Day, Year)	32. Regist	rar's Signature							

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygien 37866 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** Pear1 Sandler November 20, 2005 4:00 A /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Kris Linth Assisted Living Anne Arundel Davidsonville 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 6. Sex **Funeral** 1□M 2X F Yrs. 88 August 7, 1917 Pennsylvania Director 189-03-4605 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mantal Hygiene. Important: If item 27 is marked other than "natural", or itema 23a or 28a-f ahov amy injury or other traumatic event, the Madical Examinating must be mutilled at once. 1 X Yes 2 No Directo Maryland Prince Georges Bowie 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1404 Pennington Lane 20716 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No þ If Yes, Give Year or Dates: Specify: Specify: 3 XWidowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hospital Elementary/Secondary (0-12) College (1-4or 5+) Medical Records 12 Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Joseph Kaufer Gussie Bransdorf 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darrielle Sugarman/Daughter 1404 Pennington Lane, Bowie, MD 20716 20b. Place of Disposition (Name of cometery, crematory or other place)
Geo. Washington Uni.
Medical Center 20c. Location - City or Town, State 20a. Method of Disposition November 20 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 X Donation 5 ☐ Other (Specify) 2005 Washington, DC 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Columbia Mortuary Services, Inc. P.O. Box 58007 Washington, DC 20037 Jonenico Umode 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** weeks Sepsis /Medical Due to (or as a consequence of) Examiner Cholecystitis weeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed the attending physicien and the for use as the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 □Ectopic pregnancy in the past 12 months?
1 Yes 2 XNo Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 ☐ Probably 4 ☐Unknown 1 ☐ Yes 2 No Breast Cancer Completed peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? has 1 ☐ Yes or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Assisted Living Other: 4 Nursing Home 5 Residence 6X Other (Specify) ٥ 2 ER/Outpatient 1 ☐ Yes 2 🛣 No 3□ DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Medical Certification; After Injury 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel within 24 hours To the Funerel 🖔 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D26199 November 23, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2191 Defense Highway, Crofton, MD 21114 Emily A. Ulmer, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

			For State Registrar	State of Ma	-		tment of He			giene Rog. No. 1	5 37067
7	Physici /Medic		Decedent's Name (First, Middle, Last)     Ca	therine El	izabeth	Sau	ter		2. Date of De Month Nov EmB	Day Ye	3. Time of Death
**	Examir			spital	/la con la chier			ocation of Dea			altimore City
79.	Funeral Director		5. Social Security Number 6. Sex 213-03-1987  Usual Residence of Decedent	M 2XF	(In yrs. last bir		Months Days	Hours Mir		y, Year)	Birthplace (State or Foreign Country)  Maryland
	ter death with the Maryland tams 23a or 28a-f ehow recritives be notified at	Director		ward	10c. City, Tow	n or Loca	Elli	cott City			10d. Inside City Limits 1 ☐ Yes 2 📉 No
	ath with the 23a or 2	rai Dire	10e. Street and Number 3494 Walker Dr.				10f. Zip Code	21042		10g. Citizen of Wha	t Country? U.S.A.
036	72 hours after death with the Maryland natural; or items 23a or 28a-f ehow Jisal Ezardiral from Le notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 250 N If Yes, Give Year or Dates:		lf Y	as Decedent of His res, specify Cuban Yes 250 No	panic Origin? ( , Mexican, Pue Specify:	Specify Yes or No arto Rican, etc.)		American Indian, White, etc. White
21215-0036	within ene. then "	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5-		(Give kir	nt's Usual Occupat nd of work done du NOT use retired) Hom	ion iring most of w iemaker	orking	16b. Kind of Busin	ess/Industry Iwn Home
land 2	ರ ಕ ಶ ಕ	To Be Co	17. Father's Name (First, Middle, Last)	ce Abel					ame (First, Middle,	Maiden Sumame) Estelle Day	
Maryland	and and ie m	F	19a. Informant's Name/Relationship (Ty)  Ms. Judy Jefferson			_			Rural Route Number	er, City or Town, Sta	te, Zip Code)
Baltimore,	0 0		20a. Method of Disposition  1 Burial 2 Cremation 3 R  4 Donation 5 Other (Specify)		20b. Place of cemeter	Disposit y, crema			Date 1/21/2005	20c. Location - City	y or Town, State City, Maryland
Balti	permit. Pag Depertment important: i eny injury o once.		21. Signeture of Funeral Service License	entruch	M0129:	3 22.1	Slack Ft 3871 Ol	of Facility uneral Hor d Columbi	ia Pike Ellicot	tt City, MD 21	043
e in	Physician		23a. Part 1 Serier the disease, or complishock, or heert failure. List only on Immediate Cause (Final disease or condition				the mode of dying,			rest.	Approximate Interval Between Onset and Death
A.	/Medical Examiner		resulting in death)  Sequentially list conditions,	). <del> </del>							
8760, \(\neg \)	cate be executed physicien and the burial-transit	dicai Examine	if any, feeding to infunediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		consequence						
.O. Box 6	death certifii e attending p od for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 □ Live birth 24 □ Pregnant at 19 □ Unknown	2 ☐ Fetal death		ctopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
<b>a</b>	sign d be	þ	Part II. Other significant conditions con	tributing to death bu	t not resulting in	the unde	erlying cause given	in Part I.			te to the cause of death?  Probably 4 □Unknown
Vital Records,		Completed	Hyper choksteroles	nia						rmed?// deat	e autopsy findings available to completion of cause of h? Yes 2 No
f Vita	nysici nis cen direc	To Be	25. Was case referred to medical examiner?  1  Yes 2 No	ospital: 1 npatier	nt 2□ER/Ou	tpatient	3□ DOA Other		eath Check only o	nel lence 6 □Other (S	Specify)
Division of	After		27. Manner of Death  1 Natural 5 Pending  2 Accident investigation	28a. Date of Injury (Month, Day		Time of njury	28c. Injury a Work? M 1 ☐ Ye	at es 2⊡No	28d. Describe h	ow injury occurred	
Divis	ital or Attend irs after death ral Director: , led in by the f	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inju- building, etc.	(Specify)				City or Tow	m, State)	r Rural Route Number,
	To the Hospital or At within 24 hours after or To the Funeral Directompletely filled in by	edical	29a. Certifier 1 Certifying Phys (Check only 2 Medical Examinone)	sician: To the best of ner: On the basis of and manner stat	examination and	, death o d/or inves	ccurred at the time stigation, in my opin	, date and place nion, death occ	ce, and due to the courred at the time, of	cause(s) and manne date and place, and	r as stated. due to the cause(s)
	To the within 2 To the complete	Σ	29b. Signature and title of certifier  Molam m	) mo			29c. License			29d. Date signed (M	onth, Day, Year)
	5		30. Name and address of person who co	mpleted cause of de	ath (Item 23a) (	Type, Pri		the nd	· ( R. 11	N Dr	mi
	Sta Registr		31. Date filed (Month, Day, Year)  NOV 2 3 2		r's Signature		berte	module	n fine	I I I	v

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Privacion   Priv	Ë	Page nent ( ant: If ury or		4 Donation	5 ☐ Other (Specif	Premoval from State					11.2	3.2005	St	JRVEYOR.	. WV	
23. Part   Erier this declaration   Approximate clause (Fine Indication of the Color of the Co	3alt	aparti nport ny inj nce.		21. Signature of Fu	uneral Service Live	1990		F1	Name and Ad	ddress of F	acility HOME -	P.A.				
Narcotics And Cocaine Intoxication   Ones and Consequence of the Comment of the		20 E € α						8 7.2	6 CRAT	N HUV	CLIC	I EM DIE	NIE,	MD 210		
September   Sept	-			shock, or hea	ant lakure. List only	one cause on each lir	the death	. Do not ente	er the mode of	dying, such	n as cardiac	or respiratory	arrest,		Interv	al Between
South laby list conditions as consequence oil):    South laby list conditions   South laby list laby list laby laby list laby laby list laby laby list laby laby laby laby laby laby laby laby				disease or dition death)	on	w			ne Inte	oxica	tion					
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Description of the past 12 months?    PERMALE: 23b Was denoted pregnant in the past 12 months?   1   vs s 2   No   2   N	4		je	Sequentially list co	onditions, nmediate		a consequ	ience ol):								
The second of th		ocuted nd transi	ami	that initiated event	injury s	с.										
FFEMALE   236. If yes, outcome of pregnancy   1   Live birth   2   Felal death   3   Ectropic pregnancy   1   Live birth   2   Felal death   3   Ectropic pregnancy   1   Live birth   2   Felal death   3   Ectropic pregnancy   1   Live birth   2   Felal death   3   Ectropic pregnancy   1   Live birth   2   Felal death   3   Ectropic pregnancy   1   Live birth   2   Felal death   3   Ectropic pregnancy   1   Live birth   2   Felal death   3   Ectropic pregnancy   1   Live birth   2   Felal death   3   Ectropic pregnancy   1   Live birth   2   Felal death   3   Ectropic pregnancy   1   Live birth   2   Live birth   2   Ectropic pregnancy   1   Live birth   2   Live birth   2   Live birth   2   Ectropic pregnancy   1   Live birth   2   Live birth	90,	oe execian a		resulting in death)	Last	Due to (or as	a consequ	ience ol):								
Second   S		physicate by the p	dica		•	d									-	
Second   S	×	certifi nding use as	√/Me		nt pregnant									23d. Date of o	delivery	
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O.C.M.E. November 18, 2005  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  ANA RUBIO, MD 111 Penn Street, Baltimore, Maryland 21201  State Registrar  DHMH 17 Rev 1/2001	ord	een s	ted									1	] Yes	2 ∐ No 3 □	Probably	4 Nnknown
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O.C.M.E. November 18, 2005  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  ANA RUBIO, MD 111 Penn Street, Baltimore, Maryland 21201  State Registrar  DHMH 17 Rev 1/2001	Ξ	r Atte	ı i i		6 ACould not be determined	286. Place of inju	ury - At ho	me, larm, stre	et, lactory, off	ice		28f. Location City or T	(Street a	and Number or	Rural Route	Number Tre
O.C.M.E. November 18, 2005  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  ANA RUBIO, MD 111 Penn Street, Baltimore, Maryland 21201  State Registrar  DHMH 17 Rev 1/2001	Q	urs af urs af eral D														
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O.C.M.E. November 18, 2005  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  ANA RUBIO, MD 111 Penn Street, Baltimore, Maryland 21201  State Registrar  DHMH 17 Rev 1/2001		o the	Me		title of certifier	and manner ste			29c. Lic	ense numb	Der		29d. D	ate signed (Mo	nth, Day, Y	ear)
State Registrar  NOV 2 3 2005  DHMH 17 Rev 1/2001  ANA RUBIO , MD  111 Penn Street, Baltimore, Maryland 21201  32. Registrar's Signature		F>F0		•	anot2				0.C.	M.E.			Nov	ember 1	8, 20	05
State Registrar  NOV 2 3 2005  DHMH 17 Rev 1/2001  31. Date filed (Month, Day, Year)  NOV 2 3 2005				30. Name and add	ress of person who	completed cause of d	eath (Item	23a) (Type, I	Print)							
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DHMH 17 Nev 1/2001	D11	1		N	OV 2 3 20	05	- L	K And	and y							
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		•	For State Registrar	State of Maryla		artment of H tificate of L			giene 005	37869
. *	Physici		1. Decedent's Name (First, Middle, Las	()		Tule	N.	2. Date of Dea Month	Day Yea	
	/Medio Examir		4a. Facility Name (If not institution, give	your Hospti	(L)	4b. City, Town, or	Location of De	ath City	4c. County of Do	
1497	Funeral Director			OM 2□F 18	Vre	Months Days	Hours Mi		7, Year) 3–87	Country) Md.
	Maryland f show	tor	10a. State 10b. County	10c. C	ity, Town or Lo	cation ltimore				10d. Inside City Limits 1 X Yes 2 No
	with the ta or 28a- t be notif	Direc	10e. Street and Number 1213 Madison Ave			101. Zip Code 212	7		10g. Citizen of What	Country?
920	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. I then the matural; or items 23a or 28a-f show item 27 is marked other then "natural; or items 23a or 28a-f show other traumatic event, the Medical Examinat must be notified at	by Funeral Director	11. Marital Status  1  Nover Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Amed Forces?  1  Yes 2 No If Yes, Give Year or Dates:	i			(Specify Yes or No- erto Rican, etc.)	14. Race - Al Black, W Specify: B	
21215-0036	filed within 72 ho Hygiene. other than "natur ant, the Medical	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 10th grade	ucation de <i>completed)</i> College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done o DO NOT use retired	durina most of w	rorking	16b. Kind of Busine Public Sc	
Maryland	should be filed nd Mental Hygis marked other umatic svant, II	To Be C	17. Father's Name (First, Middle, Last) Vincent	Lee		er, Sr.	Cher	ame (First, Middle, risse Whit	ehead	
	1 and 2 sho Health and I Iem 27 is me		19a. Informant's Name/Relationship (7 Cherisse Whitehe						r, City or Town, State , Baltimor	e. Zip Code) 21202 ce, Md.
Baltimore,	0 0		20a. Method of Disposition  1	Removal from State	Place of Dispo cemetery, creating ty	sition (Name of matory or other place	1	Date -25-05	20c. Location - City  Dundalk	
Balti	permit. Pag Department Important: i any injury o once.		21. Signature of Funeral Service Licen	Walter	A 25	Name and Address March F.		Balt: 1101 I	imore, Md. E. North A	21202 ave.
8760,	The law requires that the death certificate be executed x at the steen signed by the attending physicien and page 2 should be detached for use as the burial-transit	dical Examiner	23a a t1. Enter the disease, or companies, or heart failure. List only of the cause (Final disease or condition resulting in death)  Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a consect.)  Due to (or as a consect.)	equence of):	Hem Ora			est,	Approximate Interval Between Onset and Death I House
O. Box 6	res that the death certifica igned by the attending ph be detached for use as th	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	tal death 3	Ectopic pregnancy Other (specify)			23d. Date of o	delivery Day Year
rds, P.O.	w requires that t been signed by should be detac		Parll. Other significant conditions of	ontributing to death but not re	/	nderlying cause give Kemic			_	e to the cause of death?  Probably 4 Unknown
of Vital Records,	ysician: The law requ Is certificate hes been director, page 2 should	Completed by	Bene Manno	v Trans,	sharet			24a. Was a autop perfor 1 Yes	sy prior i	
Zi Zi	Physician: this certificant all director, i	To Be	25. Was case referred to medical examiner?  1 □ Yes 2 □ No	Hospital: 1 Inpatient 2	☐ ER/Outpatie	nt 3 DOA Othe	0.6	eath Ch ck only or	ence 6 Other (S	nacihi)
Division of	Jing Ph J. After th funeral	ation: T	27. Minner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	28c. Injun Work			ow injury occurred	poury
Divis	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec		eet, factory, office		28f. Location (S City or Tow	treet and Number or n, State)	Rural Route Number,
	To the Hospitel or within 24 hours affer to the Funerel Dir. completely filled in I	edicai	(Check only 2 Madical Exam	ysician: To the best of my ki liner: On the basis of examinand manner stated.	nowledge, deat nation and/or in	n occurred at the tim vestigation, in my op	ne, date and pla pinion, death oc	curred at the time, o	late and place, and o	tue to the cause(s)
	with To Com	Σ	29b. Signature and title of certifier	· - 5		29c. License			9d. Date signed (Mo	
6	9		30. Name and address of person who	completed cause of death (Ita	m 23a) (Type,	0.1.11	4569	21	111181	2003
2	Sta	-	AETE, 2 J. MOGAY 31. Date filed (Month, Day, Year)	32. Registrar's Sign	000 N	01274 W	olfe S	TIZEFT, T	ATEMORE	2005 E. MD 2,287
*	Regist	rar	NOV 2 3	2005 Alexan	20 19	5-0701				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Nov 20, **Physician** 2005 6:30A Helen С. Tunstall /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 183 B. Court Lothian Anne Arundel If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Feb 14, 1924 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 475 26 5640 1 □ M 2 □XF Yrs. 81 Director Staples, Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "naturel", or items 23a or 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes XXNo Directo Maryland Anne Arundel Lothian 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 183 B. Court 20711 United States Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2√VNo If Yes, Give 11 Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: ð 3 Widowed A Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sales Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental permit. Pages 1 and 2 should be Depertment of Health and Mental Important: If item 27 is marked any injury or other traumatic evone. James W. Tunstall, Jr. Helen Charlotte Johns 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James W. Tunstall, III (SON) 6635 Southern MD Blvd, Owings, MD 20736 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lee Crematory Nov 20,2005 Clinton, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Rd, Clinton, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Physician cancer /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Exami physicien ar s the burial-t Due to (or as a consequence of): Box 68760 Physician/Medical attending for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Vinknown this certificate has been siral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2√√√No 1 🗌 Inpatient Certification: To 2 ER/Outpatient 3 DOA 27. Manney of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide (V Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: Un the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical Check only the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0057400 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lynn Thomas, M.D. 1221 Mercantile Lane, Largo, MD 31. Date filed (Month, Day, Year) NOV 23 32. Registrar's Signature State 2005 Registrar

		-	For State of Maryland		rtment of H tificate of L			ene 2.00	5 (	37871
	Physicia		1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day	Yeer	3. Time of Death
	/Medic	al .		Volz,		1 1 10 10 15	NOVEMBER	4c. County	2005	0635 Hours
	Examin	er	4a. Fecility Name (If not institution, give street and number) IVV Hall Geriatric & Rehab Ctr			Location of Death		,		ore Co.
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. las		If Under 1 Year	If Under 24 Hrs.	8. Date of Birth			lace (State or Foreign
в	Director		213-26-2658 <sup>1⊠M 2□F</sup> 76	Yrs.	Months Days	Hours Min.	(Month, Day, Y May 25,			ryland
	pu 🛦 🛚	-	Usuel Residence of Decedent           10a. State         10b. County         10c. City, 7	Town or Loc	cation				1	0d. Inside City Limits
	Aaryla 1 sho	5				. 2 - 31				1 ☐ Yes 2 XNo
	the h	Funeral Director	Maryland Baltimore 10e. Street and Number		10f. Zip Code	ndalk	100	g. Citizen of W	/hat Coun	itry?
	th with	al D	7859 St. Bridget Lane			21222		United	l Sta	ites
	ems ems	iner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Oecedent of Hi Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		- Americ	an Indian, etc.
36	72 hours after death with the Maryland naturel', or Hems 23s or 28s-1 show Jisal Exacilizat must be notified at	by F.	1 □ Never Married 2 ☑ Married 1 ☑ Yes 2 □ No If Yes, Give 3 □ Widowed 4 □ Divorced Year or Dates: 1 0 1 7 - 5	1	☐Yes 2MNo	Specify:		Specify:	t.71-	
215-0036	hour turel	ed b	1547 5	16a. Deced	ent's Usual Occupa	ation	16	Sb. Kind of Bu		dustry
215	in 72	plet	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give i	kind of work done of OO NOT use retired	turing most of work	ring			,
212	ed within giene. er than "	Completed	12 Years		Conductor			Amtrak		. Road
nd	12 should be filed within in and Mental Hygiene. 7 Is marked other than "traumatic event, If a Men	Be	17. Father's Name (First, Middle, Last)				e (First, Middle, Ma		9)	
Z   S	d Men narke	2	Charles A. Volz  19a Informant's Name/Relationship (Type, Print)	10b Mailie	a Address (Street		y Hacket		State Zin	Code
Maryland	d 2 st th and th and traur		Mrs. Thelma E. Volz (Wife)				ne Dunda.			
ē,	f Heal	Ì	cem	e of Dispo	sition (Name of natory or other place		Date 20	Oc. Location - 0	City or To	wn, State
E	Page: nent o int: If		19 Burial 2   Cremation 3   Bemoval from State			· 1	16/2005	Baltin	nore,	Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or items 23s or 28a-1 show empiripary or other traumatic event, If a Medical Examinet man be notified at once.		21. Signature of Funeral Service Licensee				Home of Du			
			23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.				ndalk, Maj or respiratory arres		212	Approximate Interval Between
All I	Pnysician		Immediate Cause (Final disease or condition	200	ATHY					Onset and Death
	/Medical		resulting in death)  Due to (or as a consequent	nce of):	4					
	Examiner		Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequent		174				_	
ېو	ted 1sit	niner	cause. Enter Underlying Cause (Disease or injury		ARTER	4 DIG	FARE			
1.	execur n and al-trai	Examin	resulting in death) Last Due to (or as a consequent	nce of):		, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	01130			
8760,	ate be executed bhysician and the burial-transit		O. DIAB	, E 7	ES					
9	certificate iding phys	Medi	IF FEMALE:		10					
Box	death certifica e attending ph ed for use as th	Physician/Medical	23b. Was decedent pregnant    23c. If yes, outcome of pregnance   1   Live birth   2   Fetal decedent pregnance   1   Live birth   2   Fetal decedent pregnance   1   Live birth   2   Fetal decedent pregnance   1   Live birth   2   Fetal decedent pregnance   1   Live birth   2   Fetal decedent pregnance   1   Live birth   2   Fetal decedent pregnance   1   Live birth   2   Fetal decedent pregnance   1   Live birth   2   Fetal decedent pregnance   1   Live birth   2   Fetal decedent pregnance   1   Live birth   2   Fetal decedent pregnance   1   Live birth   2   Fetal decedent pregnance   1   Live birth   2   Fetal decedent pregnance   1   Live birth   2   Fetal decedent pregnance   1   Live birth   2   Fetal decedent pregnance   1   Live birth   2   Fetal decedent pregnance   1   Live birth   2   Fetal decedent pregnance   1   Live birth   2   Fetal decedent pregnance   1   Live birth   2   Live	eath 3	Ectopic pregnancy			23d. Date Mor	e of delive	ery Day Year
P.O. I	0 0	yslc	1 Yes 2 No 9 Unknown	.n 5∟	Other (specify)	-				
	requires that the deen signed by the nould be detached	y Ph	Part II. Other significant conditions contributing to death but not resulti	ng in the ur	nderlying cause give	en in Part I.	23e. Did toba	cco use contri	ibute to th	ne cause of death?
rds	quires n sign ald be	ed by	ANEMIA				1 ☐ Yes	2 🗆 No	3 Prob	ably A Unknown
Vital Records,	~ Q 70	Completed					24a. Was an autopsy	24b. V	Vere autor	psy findings available mpletion of cause of
Re	0 4 0	mo					performe	ed? d	eath?	AD-No
ita	ysicien: The is certificate director, pag	Bec	25. Was case referred to medical examiner?				th (Check only one)			
5	S 50	2	1 ☐ Yes 2 ☐ M6 Hospital: 1 ☐ Inpatient 2 ☐ EF	R/Outpatien	-	Nursing Ho	ome 5 Residen			()
on c	ng fter inel	lon:	✓ Natural 5 Pending (Month, Day Year)	8b. Time of Injury	28c. Injury Work	γat k? Yes 2 □ No	28d. Describe how	injury occurre	30	
Division of	Attending r death. ector: After by the fune	ficat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At hom building, etc. (Specify)	e, farm, str			28f. Location (Stre	et and Numbe	or Rura	ıl Route Number,
Ο	al or A safter I Dire	Certification;	4 Homicide determined building, etc. (Specify)				City or Town,	State)		
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical (	29a. Certifier (Check only one)  No Certifying Physicien: To the best of my knowle and manner stated.	edge, death n and/or in	occurred at the time vestigation, in my op	ne, date and place, pinion, death occur	and due to the cau	se(s) and mar e and place, a	ner as st ind due to	ated. the cause(s)
	within To th compl	Me	29b. Signature and title of certifier		29c. License	e number	290	d. Date signed	(Month,	Day, Year)
			Mellean ( M. 1)	•	1) 61	15845	+ N	OVEMB	ER	22 2005
	3+1		30. Name and address of person who completed cause of death (Item 2	3a) (Type,	Print)	N STRE				WD51201
	Sta Regist		31. Date filed (Month, Day, Year) 32. Registrar's Signatur	Sport .	r e					
			48	-						

			1 - For State Registrar	State of	Maryland / Department	artment of F				005	37872
	2	- 1	Decedent's Name (First, Midd	de, Last)				-	. Date of Death	. No.	3. Time of Death
	Physici		Robert Scott	Vonkor C	35			3.7	Month	Day Year	1237 PM
100	/Medic		4a. Facility Name (If not institution			4b. City, Town, o	or Location o		ovember	21, 2005 4c. County of Death	
	Examir	ier						or Death			
		di.	Upper Chesape  5. Social Security Number		I <u>L Center</u> 7. Age ( <i>In yrs. last birthday</i> )	Bel Ai		24 Hrs o	Date of Birth	Harfor	
н	Funeral			1 (XM 2 □ F	r. Age (iii yi s. iast biitiliay)	Months Days	Hours	Min.	Date of Birth (Month, Day, Y	ear) Cou	place (State or Foreign intry)
19	Director	ļ	214-50-2774 Usuat Residence of Decedent		57			S	<u>ept. 20</u>	, 1948 Mar	yland
	and		10a. State 10b. Count	У	10c. City, Town or Lo	ocation					10d. Inside City Limits
	aho	5		1							1 ☐ Yes 2 ☐ No
	Ne Ne Ne Ne Ne Ne Ne Ne Ne Ne Ne Ne Ne N	ect	Maryland Harf	ord	Joppa	T					
	vith to	Director	Tue. Street and Number			10f. Zip Code			10g	. Citizen of What Cou	intry?
	72 hours after death with the Maryland natural', or tems 23a or 28e-f show disal Examinar must be rosilled at	Funerai	508 Anchor			21085				USA	
	ep J	ne	11. Marital Status	12. Was Dece Armed Fo	dent Ever in U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Orig	gin? (Specif	y Yes or No- an, etc.)	14. Race - Amer Black, White	
98	or after	Y	1 ☐ Never Married 2 🔀 Ma	rned 1 ☐ Yes	2 (2)No	1 ☐ Yes 2 🖺 No			,		. 0.0.
Ö	ours Fig.	d by	3 Widowed 4 Divorce	d Year or Da	ates:		Specify.			Specify:	White
21215-0036	72 P	Completed	15. Decede (Specify only high	nt's Education est grade completed)	16a. Dece	dent's Usual Occup kind of work done	ation during most	t of working	16	b. Kind of Business/li	ndustry
21	within ene. then "	npi	Elementary/Secondary (0-12)		-4or 5+) life.	DO NOT use retired	d)				
	wad w	Ş	12		Mill	wright			St	teel Manuf	acturer
nd	be filed within 72 hours after death with the Manylar ital Hygiene.  od other than "natural", or items 23a or 28e-f show other than "natural", or items 23a or 28e-f show event. The Medical Examiner must be notified at	Be	17. Father's Name (First, Middle				18. Mothe	er's Name (F	First, Middle, Ma	iden Sumame)	
Maryland	12 should be filed within h and Mental Hygiene. 7 is marked other than "raumatic event, tra Men	2	Winfield Scot	tt Venker			Pat	ricia	Kathe	rine Care	У
an	s 1 and 2 should f Health and Mer item 27 is marke other traumatic	10	19a. Informant's Name/Relation	ship (Type, Print)	19b. Maili	ng Address (Street	and Numbe	er or Rural F	Poute Number, C	City or Town, State, Zi	p Code)
	1 and 2 Health a tem 27 is		Deborah L. Ver	nker / Wife	508	Anchor Dr	ive.	Jocca	. Marvla	and 21085	
altimore,	s 1 and of Health item 27 other tr	F	20a. Method of Disposition		20b. Place of Dispo	sition (Name of	1	Date	-	c. Location - City or T	own, State
0			1. Burial 2 Cremation		State	matory or other plac	· 1				_
Ħ	그 든 뿐 글		4 Donation 5 Other (	Specify) Entomb						Bel Air, M	aryland
Ba	permi Depar Impor any ir		21. Signature of Funeral Service	e Licensee		comas aru			•		
	TO T & C		suffer a	1 Neeps						on, Maryla	nd 21009
b,			23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complications that cast only one cause on e	aused the death. Do not en ach line.	ter the mode of dyir	ng, such as	cardiac or re	espiratory arrest		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		Septic S	nnch				(4)	Onset and Death
	/Medical		resulting in death)	Due to (	or as a consequence of):	····					
*	Examiner				Severe	Sepail					
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (	or as a consequence of).						
	uted J ansit	Examiner	Cause (Disease or injury		Ungse	WEU DECK	Chan	شر اور	laur		
,	al-tra	Xa	resulting in death) Last	C. Due to (	or as a consequence of):	430. 1	(		,,,,,,		
8760,	cate be executed physicien and the burial-transit										
687	phy:	dicai		d							
	The law requires that the death certific the has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE:	23c If yes out	come of pregnancy						
Вох	ath dath dath d	lan	23b. Was decedent pregnant in the past 12 months?	1☐Live b	irth 2 ☐ Fetal death 3 ☐	Ectopic pregnancy	/			23d. Date of delive	ery Day Year
0	e de the a	S	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregn 9☐Unkno		Other (specify)					, , , ,
Ρ.	that the de led by the a detached i	F.		-				_		1	
	esth igner	Ď	Part II. Other significant condit	tions contributing to de	ath but not resulting in the u	nderlying cause giv	en in Part I.		23e. Did tobac	co use contribute to	the cause of death?
p	en si ould	P							1 🗆 Yes	2 □No 3 □ Pro	babiy 4 □Unknown
Records,	sw request speen	Completed						0	24a. Was an	24b. Were aut	opsy lindings available
Re	The lav	Ĕ							autopsy performe 1 Yes 20	prior to co	ompletion of cause of
a		ပိ	25. Was case referred to medical	21						No 1 ☐ Yes	2 No
Vital	Physicien: this certific	0 8	examiner?	Hospital:	/	oth	or		check only one		
6	hys this	-	1 Yes 2 No 27. Manner of Death	28a Date	npatient 2 ER/Outpatier	II JLI DOA	4 🗀 Nu			e 6 □Other (Speci	fy)
		io	1 ☑Natural 5 ☐ Pendi	ling (Mont	of Injury 28b. Time o h, Day Year) Injury	Wor			I. Describe how	injury occurred	
Division	eatl or:	cat	2 Accident invest	tigation			Yes 2 1	No			
≥	or Attendation of the order of the order o	Ħ	4 Homicide deter	mined 200. Place	of Injury - At home, farm, str ng, etc. <i>(Specify)</i>	reet, factory, office		28f	Location (Street City or Town, S	et and Number or Rur State)	al Route Number,
	To the Hospitel or Att within 24 hours after d To the Funerel Direct completely filled in by	Certification								•	
	ospl hou uner ly fill	ca i	29a. Certifier 1 Certifyi	ing Physicien: To the	best of my knowledge, deat	h occurred at the tir	ne, date and	d place, and	due to the caus	se(s) and manner as	stated.
	n 24 he Fi	Medicai	one)	and manr	isis or examination and/or in	vestigation, in my o	pinion, deat	tn occurred	at the time, date	and place, and due t	o the cause(s)
	To the Within To the Tooms	Σ	29b. Signature and itle of certific	ier		29c. Licens			29d.	. Date signed (Month,	Day, Year)
			12m 18	110		Do	0063	12 n		11/21/05	
	9		30. Name and address of person	n who completed arms	e of death (Item 22s) (To			-120		1 - 1, 103	
	100						D - 1	70.4.	1.5	3 04 05 :	
5.	W.		Zubair A. Sido 31. Date filed (Month, Day, Year	auq 300	Upper Chesap	eake Dr.,	ReT	Alr,	warylan	a 21014	
1	Sta Registi		MOV 2. 3	2005	egistrar's Signature	MEL					
1	9131		MOV 2	LUUJ KANA	1						

3

Robert Venker M800314383

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** CJ Vaughn November 2005 18 Ρ 6:10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1X M 2□ F Yrs Director 218-34-2399 65 June 2, 1940 Virginia Usual Residence of Decedent filed within 72 hours after deeth with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or Itams 23a or 28a-f ehow the Medical Exprimer; just be notified at Director ty∑Yes 2 No MD Crofton Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1835 N. Forest Court, Apt. 21114 USA Completed by Funeral 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXXVo Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 6th Ø Truck Driver State Highway permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy, Important: If item 27 ie marked any Injury or collection other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Claude Vaughn Anna May Spears 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Vaughn/Wife 1835 N. Forest Court, Apt. C, Crofton, MD 21114 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem. Pk 11/23/2005 Elkridge, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Donaldson Funeral Home, 313 Talbott Avenue, Laurel, MD 20707 √M01103 Hanulo or 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Sepsis /Medical Due to (or as a consequence of): **Examiner** bactremia ohlococer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit and resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, the attending physician Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No be detached 9☐Unknown 9 Unknown δ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Tyes 2 No 3 Probably 4 Unknown should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an page 2 has certificate 1 Yes 2 No Hospital or Attanding Physician: filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Medicai Certification; To 1 Tyes 1 Inpatient 2 ER/Outpatient 3□ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death.

Funaral Diractor: A 2 Accident 6 Could not be determined 3 Suicide 28e. Place ol Injury - At home, farm, street, lactory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 2. 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) ٥ 2 D58510 dress of person who completed cause of death (Item 23a) (Type, Print) 30. Name lexo 32. Rastrar's Signature State Registrar

			For State Registrar	State of Marylan		artmer rtificat			nd Me		ene 0 (	)5	37874
	Physici /Medic	167	1. Decedent's Name (First, Middle, Last, CHARLES W. WILSO							Date of Death		ď5°	3. Time of Death 5:30P M
	Examin	_	4a. Facility Name (If not institution, give 102 S. Highland	Avenue		Bal	Town, or timo	Location of re  If Under 2		D-t- of Birth	4c. County Balti	more	
E	Funeral Director		21043240007	7. Age (In yrs. 68	Yrs.	Months		Hours	Min.	Date of Birth (Month, Day, lay 21,	1937		place (State or Foreigr ntry) ryland
	Be-f ehow	Director	Usual Residence of Decedent  10a. State 10b. County  Maryland Baltimor		by, Town or Lo	imore		у					10d. Inside City Limits 1   Yes 2   No
	th with the	ai Dire	10e. Street and Number 102 S. Highland Av	enue		10f. Zij	o Code	2122	24	110	g. Citizen of V USA	Vhat Cou	ntry?
980	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If item 27 is marked other then "natural", or items 23a or 286-f show or other traumatic event, the Madical Examinational Leading 1 at or other traumatic event, the Madical Examinational Leading 1 at	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed	12. Was Decedent Ever in U Armed Forces? NOXYes 2 No If Yes, Give Year or Dates:	an 13.	Was Dece If Yes, spe			in? (Speci Puerto Ri	fy Yes or No- can, etc.)	Blac	e - Ameri k, White, , Whi	
Maryland 21215-0036	within 72 ho ane. then "natur the Medical	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 10 yrs.	cation le completed) Cotlege (1-4or 5+)		dent's Usu kind of wo DO NOT L	ork done d ise retired	ation during most	of working	7	6b. Kind of Bu		-
land 2	d 2 should be filed within h and Mental Hygiene. 7 le marked other then "traumatic event, the Mes	To Be Co	17. Father's Name (First, Middle, Last) Charles W. Wilson,		1020				's Name (	First, Middle, M			
Mary	and 2 shoule and A may be may be may be traumand her traumand her traumand may be may		19a. Informant's Name/Relationship (T) Eileen W. Adkins (			•	,			Route Number, .timore,			o Code)
Baltimore,	pernit. Pages 1 and Department of Health Important: If item 27 any injury or other tr once.		20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □ F  **XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	Removal from State	Place of Dispo cemetery, crei			θ)	Dai	te 2	Oc. Location -	City or T	own, State
Balt	pernit. Pag Department Important: I any injury o		21. Signature of Funer lice Licens Ronald S. W	ade, Director	St ——Ba	ate A 1timo			ard 6 1201	555 W. I	Baltimo	re S	treet
. ×	Physician /Medical Examiner		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ilications that caused the deal ne cause on each line.  a. Myoca  Due to (or as a consect)  b. Coronal						respiratory arre	st,		Approximate Interval Between Onset and Death
8760,	ite be executed sysicien and he burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	quence of):	tery	<i>,</i> a.s	lease					quears
P.O. Box 6	that the death certifica ed by the ettending ph detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of α 9 □ Unknown	al death 3	⊒Ectopic p ⊒ Other (s					23d. Dat Mo	te of deliv	ery Day Year
	quires that n signed b uld be deta		Part II. Other significant conditions co		sulting in the u	ınderlying	cause give	en in Part I.			acco use cont s 2 🗆 No	ribute to t	he cause of death?
Division of Vital Records,		Completed by	Diabetes Mel Hyperlipiden	nia				·		24a. Was ar autopsy perform 1 Yes 2	ned?	Were autoprior to co death?	opsy findings available impletion of cause of
Vita	Physician: this certific ral director,	Be	25. Was case referred to medical examiner? 1  Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	] ER/Outpatie	nt 3 D	OA Othe	25		Check only one		/0	4.3
ion of	After After	atlon; To	27. Manner of Death 1   Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		28c. Injun World		28	d. Describe ho		- ' '	9/
Divis		Certification:	3 Suicide 6 Could not be 4 Homicide determined	building, etc. (Speci						City or Town	, State)		al Route Number,
	To the Hospitel or within 24 hours ette To the Funerel Dir completely filled in I	edicai	29a. Certifier 1 ★ Certifying Phy (Check only one) 2 ■ Medical Exam	rsician: To the best of my kn- iner: On the basis of examina and manner stated.	owledge, deat ation and/or in	th occurred ivestigation	d at the tim n, in my op	ne, date and pinion, deatl	d place, an	nd due to the ca d at the time, da	use(s) and ma te and place,	and due t	stated. o the cause(s)
	To the within To the Comp	×	29b. Signature and title of certifier	n Director/	Managa		c. License		363		Noven		
			30. Name and address of person who of Sandra Mars	ompteted cause of death (Ite	m 23a) (Type,	Print)	tical	Conti	er 10	North	Green	o C+	Baltomor
- 8	St	ate	31. Date filed (Month, Day, Year)	32 Registrar's Sign	ature A	24/1	)	-0.01	,,,				MD 21201

State of Maryland / Department of Health and Mental Hygiene 0 05 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** November 20, 2005 3:00 P M James Woods /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 1926 Willow Spring Road Dundalk 8. Date of Birth (Month, Day, Year) July 11,1949 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 215-52-3596 56 Director Maryland Usuat Residence of Decedent with the Maryland 10a, State 10c. City, Town or Location 10d. Inside City Limits wode rthan "natural", or itame 23a or 28a-f ehov tra Medical Exeminar must be notified at 1 ☐ Yes 2 X No Baltimore Dundalk **Funeral Director** MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 1926 Willow Spring Road 21222 filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygier Important: If item 27 ie marked other tt any injury or other traumatic event, IIIa once. 12 years Trucking Dispatcher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Gene Woods Delphia Angelini 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1926 Willow Spring Road, Dundalk, MD. 21222 Marie Woods spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State November 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Bayview Crematory 4 □ Donation 5 □ Other (Specify) 21,2005 Baltimore, MD. 21. Signature of Funeral Service Licensee <sup>22 Name and Address of Facility</sup> Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) **Physician** Lun 11 month /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): physician s the burial P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by Metastones 1 Yes 2 No 3 Probably 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? 2/2 No 1 Yes 2 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 1 ☐ Yes 2 No Certification; To 5 Residence 6 □Other (Specify) his 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of 1 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation the 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 🗌 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 024356 Nov 21, 2005 9103 Franklin Sq. Dr Suite 2200 Rosedale, MD.21237 of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 2 3 2005 Registrar

State of Maryland / Department of Health and Mental Hygien 005

			1 - State Amend Item//	18 per INF	G849 11	122/0	calle of	Death	,	Reg. No.	0 01010
	÷	in.	Decedent's Name (First, Middle,						2. Date of De	aath	3. Time of Death
	Physici		BAR BARA	WIL	VES				Month NOJEMB		os 1627 P M
	/Medic		4a. Facility Name (If not institution,			41	City Town	or Location of Dea		4c. County of I	
	Examir	er				-		AU STOW			
			5. Social Security Number 6	HOSPITAL Sex 7. AO	e (In yrs. last t	hirthday) If	Under 1 Year				more
	Funeral Director			1 □ M 2 1 □ F			onths Days			ay, Year)	Birthplace (State or Foreign Country)
			213-30-0383 Usual Residence of Decedent		76				11-2	3-1920	Md
	wc Mc		10a, State 10b. County		10c. City, To	wn or Location	on				10d. Inside City Limits
	dary	ŏ	Md Balto		Wood1a	awn					1 ☐ Yes 2 No
	the f	Director	10e. Street and Number				Of 7:- Code			40- 02	
	with por						Of. Zip Code			10g. Citizen of Wha	it Country?
	ath 23	Funerai	10 Pea Pod Ct	1			2120			USA	
	er de	nue	11. Marital Status	12. Was Decedent Armed Forces?		13. Was	Decedent of his, specify Cub	lispanic Origin? ( an, Mexican, Pue	Specify Yes or No nto Rican, etc.)	D- 14. Race - A	American Indian, White, etc.
36	within 72 hours after death with the Maryland ene. then "nature!; or iteme 23a or 28a-1 ehow ta Mudical Examinar riunt be coulded at	by F	1 Never Married 2 Married	If Yes, Give	No	10	Yes 20X No	Specify:			Black
	ure!	d b	3 ☐ Widowed 4 ☑ Divorced	Year or Dates:							
7	"nai	Completed	15. Decedent's (Specify only highest	grade completed)	16	(Give kind	's Usual Occur of work done	during most of wo	orking	16b. Kind of Busin	
21215-0036	withii one. then	ם	Elementary/Secondary (0-12)	College (1-4or 5			NOT use retire	<i>a)</i>		Baltimore	•
2	led y	ပိ	12th grade  17. Father's Name (First, Middle, La	6 years		reache	r			Public S	Schools
ŭ	be fi	Be		,						, Maiden Sumame)	
χ	Mer Mer Marke	မ	Bernard Colber							Alice Colb	
Maryland	and and le m		19a. Informant's Name/Relationship							er, City or Town, Sta	
2	and ealth n 27		Howard Wilkes,	Jr - Son		-		on BIAG	Apt 844	Arlington	n, Va 22209
920	of H		20a. Method of Disposition 1   Burial 2 □ Cremation 3	□ Removal from State	20b. Place cemei	of Dispositio	n (Name of any or other place	ce)	Date	20c. Location - City	y or Town, State
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other then "naturel", or iteme 23a or 28a-f show any njury or other treumatic event, the Mudical Examinator may be notified at another.		4 □Donation 5 □Other (Spe		Arbut	tus Me	morial	Park 11	1-29-05	Arbutus,	Md
a	mit.	1 1	21 Signature of Funeral Service Lie	ensee / .		22. Na	ame and Addre	ess of Facility	March F	/H West	
n	88 5 8	1	> xumain	UNALLI	W/4			4300	Wabash .	Avenue Bal	Lto, Md 21215
	A .W		23a. /art1. Enter the disease, or co shock, or heart failure. List or	omplications that caused	the death. Do	o not enter th	ne mode of dyir	ng, such as cardia	ic or respiratory a	rrest,	Approximate
		J.	1 mediate Cause (Final		_						Interval Between Onset and Death
18	Physician /Medical		di ease or condition esulting in death)	a Me thici Due to (or as	Min Ma	whene	Stophy	become !	conen ,	neumonia	taux
	Examiner	V		W771000							
4_		-	Sequentially list conditions,	b. Dive to lor as	a consequenc	a of): Tax	elleri		-		days
	ed	Ę	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	200 (0) 23	a consequence	e 01).			٠		•
	and and I-trar	Examiner	that initiated events resulting in death) Last	C. Due to for as	a consequence	- Mys	ter a	lezofunch	<i></i>		days
9	be e icien buria					3 2.7.					
68760,	eath certificate be executed attending physicien and for use as the burial-transit	Medicai		d							
9 ×	ertifi ding I	We	IF FEMALE:	22- 16							
0	ath c ttenc or us	an	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1□Live birth	2 Fetal dea		opic pregnancy	y		23d. Date of Month	delivery Day Year
О	The law requires that the death ce sie hes been signed by the attendi bege 2 should be detached for use	Physician	1 ☐ Yes 2 ☒No 9 ☐ Unknown	4□Pregnant at 9□ Unknown	t time of death	5 🗆 Oth	ner (specify) _			Wichter	Day 10a
<u>d</u>	at th	F.									
	gner bed	þ	Part II. Other significant condition	s contributing to death b	ut not resulting	in the under	tying cause giv	ren in Part I.	23e. Did 1	obacco use contribu	te to the cause of death?
Vital Records,	w requires to been signer should be a	be							1 🗆	Yes 2□No 3□	Probably 4 QUnknown
ပ္က	law re es be 2 sh	Completed							24a. Was		e autopsy findings available
ř	The f	Ę								ormed? deat	
a	ician: Th certificete rector, peç	C	25. Was case referred to medical			-		26 Phon of Do	ath (Check only		Yes 2 No
5		0 8	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	ent 2 ERVO	Outpationt S	B DOA Oth			dence 6 □Other (	
Ö	Phys or this oral di	To :r	27. Manner of Death	28a. Date of Inju	ry 28b	. Time of	28c. Injur	v at	28d. Describe	how injury occurred	Specify)
o	ding h. After funer	ţio	1 Natural 5 ☐ Pending 2 ☐ Accident investiga	(Month, Da	y Year)	Injury		rk? Yes 2 □ No		,,	
S	Attending ir death. ector: After by the fune	lica	3 ☐ Suicide 6 ☐ Could no	be 280 Place of loi	urv - At home				28f Location /	Street and Number o	r Rural Route Number.
Division of	or Attendation of Director:	Certification:	4 ☐ Homicide determin	building, et	c. (Specify)	, 0.1001,	ractory, office		City or To	wn, State)	Hurar House Number,
	Hospitel 24 hours Funerel tely filled		29a. Certifier 12 Certifying	Physician: To the best	of my knowled	go dooth oo					
	To the Hospitel or Attending Phwithin 24 hours after death. To the Funerel Director: After the completely filled in by the funeral	Medicai	(Check only 2 Medical E)	aminer: On the basis o	t examination a	and/or investi	gation, in my o	ne, date and plac pinion, death occ	e, and due to the urred at the time,	date and place, and	r as stated. due to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	and manner su	2.00.		29c. Licens	e number		29d. Date signed (M	Innth Day Year
	F ≱ F 8									a	
/	1.		Shratson	MB.				05973	6	november	4, 2005
b	1		30. Name and address of person wi		leath (Item 23a	ı) (Type, Prin	t)				
	is a		DEBURAH WAT			HWEST	40261.	TAL 5	401 Our	COURT R	LOAD
100	Sta Registi		31. Date filed (Month, Day, Year)  NOV 2 3	. 67	ar's Signature	in 10					
4.0	rregisti	वा	NUV 4 3	/ UH )   Fig	e in A	17	2. M 2				

	-	State of Maryland / Department of Health and M  State Certificate of Death		giene Reg. No.	005	37877
Physician	n,	1. Decedent's Name (First, Middle, Last)  Howard Allen Wartman	2. Date of De	ath	, 2005	3. Time of Death 08:00 A M
/Medica Examine	10	ta. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death		4c. C	ounty of Death	1
	H	Greater Baltimore Medical Center Towson		Ва	1timore	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.  **Real Control of the Contro	8. Date of Bit (Month, Da	th ly, Year)	9. Birthp Cour	lace (State or Foreign
- Director	-	216-16-2951 82 Yrs. Usual Residence of Decedent	Sep.9,	1923	Mary.	
and w	-	10a. State 10b. County 10c. City, Town or Location			1	0d. Inside City Limits
Mary	0	MD Baltimore Timonium				1 ☐ Yes 2√∑No
r 28a	Director	10e. Street and Number 10f. Zip Code		10g. Citize	on of What Cour	ntry?
death with the Maryland me 23e or 28a-f show rimust be notified at	<u>a</u>	12111 Tullamore Crt. unit 304 21093		US	SA	
dea dea	Ine.	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto	ecify Yes or No Rican, etc.)	)- 14	. Race - Americ	
36 38 afte s afte	by Funeral	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No 1948 1 ☐ Yes Sirve 1 ☐ Yes Sirve 1 ☐ Yes Sirve 1 ☐ Yes Sirve Wh	ite	S	pecify: wh	
1215-0036 within 72 hours after dealene. Ithen "natural", or items to Mudical Examinar in		3 Widowed 4 Divorced Year or Dates: 1951 15. Decedent's Education 16a. Decedent's Usual Occupation		16b Kind	of Business/Inc	dustry
715 min 72	Completed	(Specify only highest grade completed)  (Give kind of work done during most of work life. DO NOT use retired)  Elementary/Secondary (0-12)  College (1-4or 5+)	ng			2001.7
d with	E	12th Supply Forman		Bell	Atlant	<u>Lc</u>
nd nd	Re	17. Father's Name (First, Middle, Last)  18. Mother's Name		, Maiden Si	umame)	
VIa Via Via Via Via Via Via Via Via Via Vi	0	Charles Wartman Margaret				
Maryland d 2 should be fill th and Mental H I? I is marked out traumatic even	1	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rura		•		
of the state of th	-	Elizabeth L. Wartman—wife 12111 Tullamore Crt. u  20a. Method of Disposition (Name of cemetery, crematory or other place)	mit 30	4 Time 20c. Loca	onium, 1	ID 21093
nor ages		1 ☑ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)  **Commetery, Crematory or other place)  Loudon Park Cemetery Nov.	26 05			
Baltimore Permit. Pages 1s Department of He Important: If item Important: If item Important: If item Interes.	1	21. Signatu, iFuneral Service Licensee 22. Name and Address of Facility Lo				
Bal permi Depa Impo		3620 Wilkens Ave. B				
		23a. Papt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card, ic costock, or heart failure. List only one cause a each line.	or respiratory a	rrest,		Approximate Interval Between
Physician	A. A. A. A. A. A. A. A. A. A. A. A. A. A	Immediate Cause (Final disease or condition PALICIE THE TAILUE	10			Onset and Death
/Medical Examiner		resulting in death)  Due t (or is a consequence of):				
* S.	_	Sequentially list conditions, if any, leading to immediate b. Dus to (or as a consequence of).			-	
27 to 12	Examiner	cause. Enter Underlying Cause (Disease or injury				
60, A	Xar	that initiated events c.  resulting in death) Last  Due to (or as a consequence of):				
	dical	d				
	Sed .	IF FEMALE:		I		
Box 6 eath certific	an/r	23b. Was decedent pregnant  1 Live birth 2 Fetal death 3 Ectopic pregnancy		23	d. Date of delive	ny Day Year
D. E. De deg	by Physician/Me	1   Yes 2   No 9   Unknown			17101111	Day Tou.
that the de detached f	7	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did 1	tobacco use	contribute to th	ne cause of death?
cords, w requires to been signed should be			10	Yes 2□	No 3∏Prob	ably 4 Unknown
w req	Completed		24a. Was	an	24b. Were auto	psy findings available impletion of cause of
Re(The lay te has age 2	E O			psy ormed? 2 2 No	prior to cor death? 1  Yes	
Vital F	BeC	25. Was case referred to medical 26. Place of Death	1 Yes		1 103	2010
of Vital Re	0	examiner?  1   Yes   2   No	me 5□Resi	dence 6[	□Other (Specif)	1)
on o		27. Manner of Death 1 XX atural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 28b. Injury at Injury	28d. Describe			
isio	cat	2 Accident investigation M 1 Yes 2 No	OOF Leasting	·C+		10-11
Division of Vital Records, to attending Physician: The law requires to after death.  Director: After this certificate has been signed in by the funeral director, page 2 should be controlled.	Certification:	4 Homicide    Suicide   See Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or To	wn, State)	vumber or Hura	l Route Number,
spita ours neral	700	29a. Certifier (Check only   Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred.	and due to the	cause(s) ar	nd manner as st	ated.
the H hin 24 the F nplete	Medic	and manner stated.	ou at the time,			
To with	-	29b. Signalure and title of certifier  29c. License number		111	signed (Month,	-uy, 10d1/
0,	}	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		11/	21/0	)
\		12221 TULLAMORE RO TIMONIUM, 1	MI) 2	109	3	
State		31. Date filed (Month, Day, Year) 32. Registrar's Signature				
Registra	r	MOVE 2 2005 Reales				

ORIGINAL

			For State	State of Ma			ment of H		ind Me		giene Reg. No	O O O P	27070
			Registrar  1. Decedent's Name (First, Middle, Last	st)			00.0 0, 2			Date of De	ath	<del></del>	3. Time of Death
	Physici		Bettie		Wakenig	ht			N	Nov 20	, 20	05 Year	5:45 A M
4	/Medic Examin		4a. Facility Name (If not institution, give				City, Town, or	Location o	f Death		4c.	County of Deal	
			Fenwick Landing			•	Valdorf					Charle	
	Funeral Director		201 20 0001	ex 7. Age	(In yrs. last bin		Under 1 Year onths Days	If Under a	Min. S	Date of Bir (Month, Da ept 1	th y. Year) 4, 1	919 We	chplace (State or Foreign St Virginia
	and *	}	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	n or Locati	on						10d. Inside City Limits
	f sho	5	Maryland Calver	.+	N <sub>O</sub>	rthbe	each						1 □Yes 2√DNo
	28a-	Directo	10e. Street and Number	L	110		Of. Zip Code				10g. Cit	izen of What Co	
	3a or		3939 Sea Sid	e Court Un	it 105	-	20714	+			Un	ited St	ates
	items 2	Funeral	11. Marital Status 1 □ Never Married 2 □ Married	12. Was Decedent E Armed Forces? 1 ∐Yes XXXN		13. Was	Decedent of Hi s, specify Cuba	ispanic Origin, Mexican	gin? (Specif , Puerto Ric	y Yes or No can, etc.)	)-	14. Race - Ame Black, Whit	e, etc.
903	hours af	by	XXXWidowed 4 ☐ Divorced  15. Decedent's E	If Yes, Give Year or Dates:			Yes 2XXXVo	Specify:	** ** **		16b K	Specify:	White
Baltimore, Maryland 21215-0036	rose 1 and 2 should be filed within 72 hours after death with the Maryland nt of Heelth and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic avant, it a Madical Examinar must be notified at	Completed	(Specify only highest gra		+)	(Give kind	of work done o NOT use retired	during most	of working				overnment
5	Hygie Hygie thert nt, #		17. Father's Name (First, Middle, Last,			Decre	cary	18. Mothe	r's Name (F	First, Middle			OVCITIMENT
and	d be formal i	o Be	Edward Murray, S					Ma	artha	A. Ta	ylor		
2	should mark mati	၉	19a. Informant's Name/Relationship (		19b	. Mailing A	ddress (Street a	and Numbe	r or Rural F	Route Numb	er, City	or Town, State,	Zip Code)
S	nd 2 state at the		Jean Smith (Daug	hter)	1	.0610	Thrift	Road	, Clir	nton,	MD	20735	
ē,	S 1 a		20a. Method of Disposition		20b. Place of cemeter	f Disposition	n (Name of ary or other plac	e) Nov	29 <sup>Dat</sup>	°2005	20c. L	ocation - City or	Town, State
Ē	Pege nat: If iry or	li	1  Burial 2  Cremation 3  4  Donation 5  Other (Special		Cedar		Cemete				Sui	tland,	Maryland
Balti	permit. Peges 1 and 2 Depertment of Heelth a Important: If Item 27 is any injury or other trat 2005.		21. Signature of Funeral Service Nice	110	01284							lome,Inc MD 2073	. 6633 01d 5
			23a. Part1. Enter the disease, or com	plications that caused	the death. Do								Approximate Interval Between
	Physician		shock, or heart failure. List only Immediate Cause (Final	one cause on each iin	6. F	000	lu di	Lho	rene	vatas	ad	enocarcin	
1	/Medical		disease or condition resulting in death)	a Due to (or as a	consequence		y au	000		- Cea		che caran	CIFIC
	Examiner		Secuentially list conditions,	b									
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$\sqrt{}$	ecute and trans	cam	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to for an	a consequence	of):							
8760,	death certificate be executed e attending physician and nd for use as the burial-transit	dical Examiner		_ d									
Õ	ntifica ng ph as th	Med	IF FEMALE:								- 1		-
Вох	aath ce attendi for use	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 ☐ Live birth 4 ☐ Pregnant at	2 🗌 Fetal death		opic pregnancy	1				23d. Date of de Month	livery Day Year
P.O.	y the	ysic	1 □ Yes 2 ☑ No 9 □ Unknown	9□ U <i>n</i> known									
	The law requires that the death certific the label signed by the attending property should be detached for use as	by Physician/Me	Part II. Other significant conditions	contributing to death bu	ut not resulting i	n the unde	rlying cause give	en in Part I		Į.			o the cause of death?
ord	w require been signature	ted							_	-	Yes 2		robably 4 Tunknown
3ec	The law cete has b	Completed								24a. Was auto perfe		death?	utopsy findings available completion of cause of
a									-15	1 ☐ Yes	2 <b>N</b> O	1 ☐ Yes	\$ 2 <b>□</b> √√0
<u> </u>	Physician: r this certific ral director.	Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital:	nt 2□ER/0i	utaatioat	3□ DOA Oth			Check only		6 ☐Other (Spe	orital
ð	ding Phys th. : After this funeral di	5	27. Manner of Death	28a. Date of Injur	y 28b.	Time of	28c. Injur			d. Describe			rciiy)
ion	Attending r death. actor: After by the funer	atlor	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	(Year)	Injury	M 1	k? Yes 2 ☐	No				
Division of Vital Records,	i Pite o	ertification;	3 Suicide 6 Could not t 4 Homicide determined		ury - At home, fa c. (Specify)	arm, street	factory, office		28	f. Location ( City or To			ural Route Number,
	Hospital 24 hours a Funeral I	edical C		hysicien: To the best of miner: On the basis of and manner sta	examination ar								
	To the within 2. To the f	Me	29b. Signature and title of certifier				29c. Licens	se number			29d. Da	ate signed (Mon	th, Day, Year)
	⊢≯⊢ŏ		•	5			D	457	37			11/21/0	5
	C		30. Name and address of person who							,			
	X		Nirmaladevi Ja			45 Pe	mbrooke	Squa	re Su	ite 10	)4, V	Waldorf,	MD 20603
	St Regist	ate	31. Date filed (Month, Day, Year) NOV 2 3 2	1	ar's Signature	A.							
DH	IMH 17 Rev 1/2			July Male	w B	1.400							

			For	,	epartment of F		ental Hygi	ene	
			State Registrar		Certificate of	Death	2. Date of Death	9. No. DOS	27270
	Physici	an	Decedent's Name (First, Middle, Last)				Month	Pay 2505	3. If Death
	/Medic	al	Edna Garne  4a. Facility Name (If not institution, give street and numbe			r Location of Death	11 /	4g. County of Dea	
	Examir	er	F C OK I COLLO CR H	6 (P. In	1 Rose,	10 10		BOIL	m = C o
green.	Funeral		5. Social Security Number 6. Sex 7. A	Age (In yrs. last birt	hday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,	9. Bir	thplace (State or Foreign
	Funeral Director		233-01-9667 <sup>1□M 2</sup> √F	90	Yrs. Months Days	Hours Min.	March 2	3,1915 We	st Virginia
	2		Usual Residence of Decedent	100 City Town					10d. Inside City Limits
	ehow	_	10a. State 10b. County	10c. City, Town	or Location				1 Yes 35No
	ith the Mi or 28a-f	Director	Maryland Baltimore		Du	ındalk	10	g. Citizen of What Co	
	ours after death with the Maryla el', or Itema 23a or 28a-1 ehov Exa oliver must be notified at	ក់	10e. Street and Number	7.1	Tor. Zip Gode	21222		VA 11	
	na 23a	era	1701 Holaview Road Apt.  11. Marital Status 12. Was Deceder	nt Ever in U.S.	13. Was Decedent of H		ecify Yes or No-	United St	erican Indian,
(0	after deal	by Funeral	Armed Forces 1 □ Never Married 2 ☑ Married 1 □ Yes 2 ☑				Rican, etc.)	Black, Whit	te, etc.
93	el', o	þ	3 ☐ Widowed 4 ☐ Divorced	3:	1 ☐ Yes 🏋 ☒ No	Specify:		Specify:	White
1/0 215-0036	"natur	Completed	15. Decedent's Education (Specify only highest grade completed)	16a.	Decedent's Usual Occup (Give kind of work done	during most of works	ng 1	6b. Kind of Business	/Industry
<u>~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~</u>	within ene. then *	du	Elementary/Secondary (0-12) College (1-40		`life. DO NOT use retired				
127	TI 70 = -		10 Years 17. Father's Name (First, Middle, Last)	As	sembly Line	18. Mother's Name	(First, Middle, M	Distille	ery
anc	ed at a	Be	Fay Bonnell				Davis		
7 2	2 should and Men le marke sumatic	ို	19a, Informant's Name/Relationship (Type, Print)	19b	Mailing Address (Street	L		City or Town, State,	Zip Code)
Ma	ith a		Charles Wolford (Son)	_ 7	404 School	Ave. Dun	dalk, Ma	ryland 2	1222
4 5	ges 1 and 2 t of Health If Item 27 or other tra		20a. Method of Disposition	cemeter	Disposition (Name of y, crematory or other place		Date 2	0c. Location - City or	Town, State
E	Pages nent of int: If It iry or o		1 🔀 Burial 2 □ Cremation 3 □ Removal from Stal 4 □ Donation 5 □ Other (Specify)	19	r Mem. Gdns	- L	005	Bel Air, I	Maryland
√ s l 1 Baltimor	permit. Pages Depertment of Important: If It any Injury or o		21. Signature of Funeral Service Licensee		22. Name and Addre	ess of Facility	Home of	Dundalk,	Inc
ے کہ	89 = 9		10000		7922 Wise	Ave. Du	ndalk. M	aryland :	21222
			23a. Part1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each	ed the death. Do r i line.	not enter the mode of dyir	ng, such as cardiac o	or respiratory arres	st.	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	onitis					1 207
-	/Medical Examiner		resulting in death)  Due to (or a	as a consequence	1	ay,			2 1.40
#	The stay of	-	Sequentially list conditions,	as a consequence	of Colon	1 de	0. 1		Adory?
ы	ited	in in	cause. Enter Underlying Cause (Disease or injury		Je.	Me 15	Find -		
0	execu n and ial-tra	Examiner	that initiated events c. Due to (or a	as a consequence	of):	1/2/	2		
8760,	cate be executed obysician and the burial-transit	dlcai	d		22	1/2/			
9	ntifica ng ph as th	Jed	IS SEMALE.			( Tri			
Вох	leath certific attending p	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcom 1 Live birth	me of pregnancy 2 Petal death		y J		23d. Date of de Month	livery Day Year
	the at	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown	t at time of death	5 ☐ Other (specify) _				July Cou.
P.O.	that the de ed by the detached		Part II. Other significant conditions contributing to death	h hut not resulting in	the underlying cause give	ven in Part I.	23e. Did toba	acco use contribute t	o the cause of death?
Division of Vital Records,	Se La	d by	Reffured Spleen		· · · · · · · · · · · · · · · · · · ·		1 ☐ Yes	s 2 No 3 P	robably 4 Unknown
Ö	w require been sign	ete					24a. Was an	24h Were a	utopsy findings available
Bec	sician: The law certificate has t irector, page 2 s	Completed					autopsy perform	ed? prior to death?	completion of cause of
<u>ta</u>	ificate or, pa	ပိ	25. Was case referred to medical			26. Place of Deatl			s 2□No
<u> </u>	ysicia s cert direct	0 8	examiner?  1 Yes 2 No  Hospital: 1 Inpa	atient 2 ER/Ou	Itpatient 3□ DOA Oth	205		nce 6 Other (Spe	ecify)
ō	ig Ph ter th neral	n: T	27. Manner of Death 1 □Natural 5 □ Pending (Month, 1)	njury 28b. 7 Day Year) I	Time of 28c. Injury Wo	ry at	28d. Describe how	w injury occurred	
<u>i</u>	endir eath. or: Af	atic	2 Accident investigation	05 un	VIONV	Yes 2 No	subjec	ct tell	at Home
Ξ̈́	fter d	Certification:	4 Homicide determined building,	etc. (Specify)	ırm, street, factory, office		28f. Location (Str. City or Town,	eet and Number or R State)	Tyral Route Number RP
	pital ours a srai D		29a. Certifier 12 Certifying Physician: To the be		a doubt accurred at the fi	mo, data and place	itt   Bo	>1+1mo/1	e ctated
	Hos 24 ho Fun stely	edical	(Check only one) and manner	s of examination an					
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate hat completely filled in by the funeral director, page	Me	29b. Signature and title of certifier		29c. Licens	se number		d. Date signed (Mon	
	F > F 0		ew Dhant	les, M	.D. D3	6663		reamond	
	E		30. Name and address of person who completed cause of	of death (Item 23a)	(Type, Print)	0 0 0 0	. 0	14.	re, MD 2123
_	5		Dr. Stuartwilles 9000		Slinsqu	orell	IVEDO	NITIMO	17/1/2/3
1		ate		istrar's Signature	Cools				
	Regist	ादा _	MOV 2 3 2005	Carling at 15	1				

			rd, Jr.  Please Amend item#27,pen/E,&  1- Stata Unpend Item Registrar			Cerun	cate of	Dealli	2. Date of Dea	eg. No		a # (Death
	Physici	an	Decedent's Name (First, Middle, La		ard All	len Ward	d, Jr.		Month	Da		3. Time of Death
\$ 1 m	/Medic Examin		4a. Facility Name (If not institution, giv	e street and number	-)	4b	. City, Town,	or Location of Deat	November 1	4c.	3, 2005 County of Deat	14:43 A
	in the second		8505 Contractor				Rosec				Baltimo	
275	Funeral		5. Social Security Number 6. S	SH OFF	ige (In yrs. las 12		Under 1 Year onths Days		(Month, Day	, Year)		hplace (State or Foreign
Colo	Director		216-78-6235 Usual Residence of Decedent						Aug. 2	, 196	os Mar	cyland
	anylan	-	10a. State 10b. County		10c. City,	Town or Location		arkville				10d. Inside City Limits 1 ☐ Yes 2€2No
	28a-f	Director	Maryland Ba.  10e. Street and Number	ltimore	<u> </u>		Of. Zip Code	TKATITE	1	10a. Cit	izen of What Co	
	ours after death with the Marylan raf', or Itama 23a or 28a-f show Examiner must be notified at		2318 Tarleton La	ane Ant.	R			21234			Jnited S	
	ama 2	Funerai	11. Marital Status	12. Was Deceden Armed Forces	t Ever in U.S.	13. Was	Decedent of s, specify Cub	Hispanic Origin? (S pan, Mexican, Puer			14. Race - Ame Black, Whit	nican Indian,
36	or It	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	1 ☐ Yes 🍇 🔀	₹No		Yes 2⊠No				Specify:	
21215-0036	2 hour		15. Decedent's E	Year or Dates ducation	- 1	16a. Decedent'	s Usual Occu	pation		16b. K	ind of Business/	Nhite Industry
215	thin 72 en *na Madi	Completed	(Specify only highest gra Elementary/Secondary (0-12)	ade completed) College (1-4or	5+)	(Give kind life. DO f	l of work done NOT use retire	during most of wo	rking			
21	ygien ygien her th	Con	12 Years			Tru	ck Dri	+				Contractors
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Ptyglene. Important: If item 27 is marked other then *natural', or itema 23e or 28e-f show any injury or other traumatic event, ir a Madical Examinat must be inclified at Once.	Be c	17. Father's Name (First, Middle, Last Richard Allen	_					me <i>(First, Middl</i> e, . therine N		,	
ary.	should nd Me mark mark	ြင	19a. Informant's Name/Relationship (			19b. Mailing A	ddress (Stree	t and Number or Ri				Zip Code)
ž	and 2 hallth a 127 is er trail		Mrs. Catherine V	Mard (Moth	er)	2318	Tarlet	on Lane	Apt. B	Par	kville,	MD 21234
ore	of He or oth		20a. Method of Disposition 12□ Surial 2 □ Cremation 3 □	Removal from State	e cen	ce of Disposition etery, cremato	ry or other pla	·		20c. Lo	ocation - City or	Town, State
Baltimore,	rtmenl rtant: njury		4 □Donation 5 □Other (Special 21. Signature of Tuneral Service Lice		st.			em. 11/23 ess of Facility	/2005	Dur	idalk, M	aryland
Ba	Department of the partment of		Seedman /	o las	L	Du	ıda-Ruc	k Funera e Ave. I	1 Home of	E Du Mar	ındalk, vland	Inc. 21222
	*		23a. Part1. Enter the disease, or comshock, or heart failure. List only	plications that cause	ed the death.						y Lana	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Multip	_	uries						Onset and Death
	/Medical Examiner		resulting in death)	a	s a conseque							
		9	Sequentially list conditions, if any, leading to immediate	b	s a conseque	nnce of):						
	ecuted nd transit	amine	Cause (Disease or injury that initiated events	C								
ó	e exec ien an ırial-tr	E	resulting in death) Last	Due to (or a	s a conseque	ence of):						
876	cate brothysic the br	dlca	•	_ d.								
Box 68760,	The law requires that the death certificate be executed the has been signed by the attending physicien and oage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE:	23c. If yes, outcom	e of pregnan	су					23d. Date of del	iverv
, B	death e atter d for L	iciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1☐Live birth 4☐Pregnant			opic pregnanc ner (s <i>pecify</i> ) _	ру 			Month	Day Year
P.O.	at the I by th	phys	9 Unknown	9□ Unknown						13		
S,	ires th signec	þ	Part II. Other significant conditions	contributing to death	but not result	ting in the under	lying cause gi	ven in Part I.	239. Did to		£ 0	o the cause of death?  obably 4 Dunknown
Sor	law requir as been s 2 should	etec							24a. Was a			
Re	he lav e has age 2	Completed							autops	sy med?	death?	topsy findings available completion of cause of
ital	iician: The lav certilicete has rector, page 2	BeC	25. Was case referred to medical					26. Place of De	1 (2¥¥es ath Check only or		75,165	2□ No
<u></u>	hyaic his ce al direc	မ	examiner? 1 A Yes 2 No			R/Outpatient 3	DOA		· · · · · · · · · · · · · · · · · · ·			cify) at scene
ü	Jing P	ion:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	Pound  28a. Date of In  (Mooth, D	jury Day Year)	Page 15 Time of Pound	28c. Inju Wo	aryat ork? ]Yes 2. <b>X</b> No	28d. Describe h	ow inju	ry occurred ut	ık
Division of Vital Records,	Attenc death ctor:	ficat	3 X Suicide 6 X Could not b	11-18-0 28e. Place of I	njury - At hom	4:38 A			28f. Location (S	treet ar	nd Number or Ru	ural Route Number,
ğ	s after s after bill Dire	Certification:	4 Homicide	Roadway	etc. (Specify)				Roseda1	n, State <b>e,</b> I	%8505Cor Md	itractors Re
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificete ha completely filled in by the funeral director, page	edicai (	(Check only 2 Medical Exa	hysician: To the bes miner: On the basis	st of my know of examination	ledge, death oc	curred at the t	me, date and place	e, and due to the curred at the time, of	ause(s	) and manner as	s stated. to the cause(s)
	thin 2, the land of the land	Med	one) 29b. Signature and title of certifier.	and manner	stated.			ise number			te signed (Mont	
	F N F S		) and	2 .			C	C.M.E.			ember 1	
		1			1			creet, Ba				

			1 - FoAmend Item#20b State Registrar Amend ITem	State of Ma per TH G	Syland/ Sol 12/	08/6 8/6	etment o	f Health a <i>f Death</i>	nd Me	ntal Hygi	ene g. No.2 () (	)5	378	81
	Physici		1. Decedent's Name (First, Middle, Last	<u></u>	Will			<del>J UII</del>	2.	Date of Death Month	_	.005	3. Time of D	Death M
porture	/Medic Examin		4a. Facility Name (If not institution, give	street and number)				n, or Location of	Death		4c. County	of Death		
			Bayview Hospital				Balto				N/A			
	Funeral Director		5. Social Security Number  263-65-2857  Usual Residence of Decedent	x 7. Age	38	Yrs.	If Under 1 Ye Months Da		Min. 8.	Date of Birth (Month, Day, 8 31	Year) 1967	Cour	olace (State or otry) orida	Foreign
	/land		10a. State 10b. County		10c. City, To	wn or Lo	cation					1	0d. Inside City	/ Limits
	Man	tor	Md N/	A	Balt	0							1 X Yes 2	2 🗌 No
	or 28	Director	10e. Street and Number				10f. Zip Cod			10	g. Citizen of W	/hat Cour	ntry?	
	ath w	ral		venue		1.5		206			USA			
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene Important: if Item 27 is marked other than *natural', or Iteme 23e or 28e-f show any injury or other traumatic event, Ite Medical Evantical must be notified at anotes.	by Funeral	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent B Armed Forces? 1 Yes 2 A If Yes, Give Year or Dates:			Was Decedent f Yes, specify C 1 ☐ Yes 2 🛣	of Hispanic Origi Cuban, Mexican, No Specify:	in? (Specify Puerto Ric	y Yes or No- an, etc.)		k, White, B1	ean Indian, etc. ack	
20	72 hc natur	etec	15. Decedent's Edi (Specify only highest grad	ucation le completed)	16	(Give	dent's Usual Oc kind of work do	ne during most	of working		6b. Kind of Bu			
12	within sne.	Completed	Elementary/Secondary (0-12) 12th grade	College (1-4or 5	†)/A C	lile. I	DO NOT use re	<sub>tired)</sub> nufactur			Blake 1	Indus	stries	
0	Hygie Hygie other ant, II		17. Father's Name (First, Middle, Last)		V/A	, II CIII J	icai Mai			irst, Middle, M	aiden Sumame	9)		
an	lid be lental ked c	To Be	Donald Williams							lliams				
ary	shou and M s mar	1-	19a. Informant's Name/Relationship (7)	ype, Print)	15	9b. Mailir	ng Address (Str	eet and Number	r or Rural R	oute Number,	City or Town, S	State, Zip	Code)	
	and 2 eaith n 27 i		Marla Williams	- Wife		4608	Chatfo	ord Aver						
Baltimore,	t. Pages 1 rtment of H rtant: If iter		20a. Method of Disposition  1★ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify)	)	Ker	Cr	<del>os</del> s Ceme	SS CATH etery 11	1-2 <b>6-</b> 2		Oc. Location - 0		Florid	
Bai	Depermine the perm		21. signature of Funeral Service Line no	, ()	1	22		Idress of Facility	Mar	ch F/H				
			23a. Part1. Enter the disease, or comp	lications that caused	the death. Do	o not ent	er the mode of		sh Ave	enue B	alto, l	Md 2	Approximate	
, i	Physician		shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on each lin	e.			In far					Onset and De	eath
	/Medical Examiner		Toolston g in south)	Due to (or as a	a consequenc	e of):								
	*	ler	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Dua to (br as a	à consequenc	e off).								
1	cate be executed physicien and the burial-transit	Examiner	Cause (Disease or injury that initiated events	С.								U		
Ö,	ate be executed hysicien and the burial-transit	EX	resulting in death) Last	Due to (or as a	a consequenc	e of):								
8760,	cate b	dicai		d										
9	eath certific attending p	/We	IF FEMALE:	23c. If yes, outcome	of pregnancy				~-					
P.O. Box	The law requires thet the death certific ste hes been signed by the attending p page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live birth 4 Pregnant at 9 Unknown	2 Fetal dea		Ectopic pregna Other (specify				23d. Date Mon		Day Ye	ar .
S,	es the igned be det	by P	Part II. Other significant conditions co	ntributing to death bu	ıt not resulting	in the ur	nderlying cause	given in Part I.		23e. Did toba	icco use contri	bute to th	ne cause of dea	ath?
ord	w require been si should t	ted	CAR dromp of a	py	2					1 🗆 Yes	2 □ No	3 Prob	abiy 4 🖼 Ún	iknown
Division of Vital Record	law r	Completed	Congestive	Happet	Failer	P			_	24a. Was an autopsy	pi	rior to cor	psy findings av	vailable use of
ᇤ			history of	/foakir	es L.	100	homa	· · · · · · · · · · · · · · · · · · ·		perform 1 Yes 2		eath?	2□ No	
<u> </u>	Physician: this certific ral director,	Be C	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:				0#		heck only one				
o	Physer this eral d	7: To	27. Manner of Death	1 ☐ Inpatie	v 28b	. Time of	3 DOA	njury at Work?		5 Residen			()	
ion	Attending ir death. ector: After by the fune	Certification:	1 Matural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	r Year)	Injury		Mork? I∐Yes 2∐N	lo					
<u>Vis</u>	r Atte er de recto by th	‡	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju-	ry - At home,	farm, str	eet, factory, offi	Ce Ce	28f.	Location (Stre City or Town,	et and Numbe	r or Rura	i Route Numbe	0 <i>r</i> ,
ā	itel or A			d'										
	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	edical	29a. Certifier 1 Secretifying Phy (Check only one) 1 Medical Exam	sician: To the best of iner: On the basis of and manner sta	examination a	ge, death and/or inv	n occurred at the vestigation, in m	e time, date and ny opinion, death	place, and occurred a	due to the cau at the time, dat	ise(s) and mar e and place, a	nner as st nd due to	ated. the cause(s)	
	To the Vithin 2 To the complet	Me	29b. Signature and title of certifier				29c. Lic	ense number			d. Date signed			
			1		> m		Do	57740		1	ovembe	1 19	\$ 12005	\$
	5		30. Name and address of person who co	P.I. Che	102		TOURSON	MO	2128	6 KA	Win J.	W,i	y, mo	
	Sta	-	31. Date filed (Month, Day, Year)	32. Registra	r's Signature	Lan	S. S							
	Registr	ar	NOV 2 3 200	The read .	15					-5.5				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 21 15:31 THEODORE JOHN ZIOLKOWSKI NOVEMBER 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner VA MEDICAL CENTER BALTIMORE BALTIMORE If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, **Funeral** Days Hours 1**X** M 2 ☐ F 215-28-1465 73 Yrs. February 8, 1932 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28e-f show the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Baltimore Dundalk 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 944 Dalton Avenue 21224 USA or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 72 hours after ty Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White δ 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 end 2 should be filed wil Deperiment of Health and Mental Hygieru Importent: If Item 27 is marked other than any injury or other treumatic svent. Printing Pressman 6 years 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Louis F. Ziolkowski Helen Gutowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 944 Dalton Avenue, Dundalk, MD. 21224 Wife Eleanor Ziolkowski 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition November 1 ☐ Burial 2XI Cremation 3 ☐ Removal from State Bayview Crematory 23, 2005 Baltimore, MD. 1.4 □Donation 5 □ Other (Specify) 21. Signature of Fufferal Service Licensee 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 8 DAYS Immediate Cause (Final disease or condition resulting in death) CARDIORENAL FAILURE **Physician** /Medical Examiner 7 YEARS DNGESTIVE HEART FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner nding physician and use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) the attending physician Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of deliven 23b. Was decedent pregnant 3 Ectopic pregnancy Day for in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 元 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No To the Hospitel or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 10 1 ☐ Yes 2 🔀 No 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification; 1 Natural 5 Pending investigation 1 Yes 2 No after death. 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier P19836 NOVEMBER 21, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.P. ION. GREENE ST. BALTIMORE, MD 21201 JAMES STRAI 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2005 NOV 2 The State of the s Registrar

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31. Date filed (Month, Day, Year)

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3	Physici	an	Decedent's Name (First, Middle, Last)			2. Date of Dea Month		Year	3. Time o 5:10	
	/Medic	al	Mary Elsie Allgood  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or L	position of Dogsth	Novembe				Рм
÷.	Examir	ier	Bayside Care Center	Lexington				t Mar		
	Funeral	3.5	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	1		place (State intry)	or Foreign
-	Director		578-20-8547 99 Yrs. Usual Residence of Decedent			August 30			1and	
	yland how		10a. State 10b. County 10c. City, Town or Lo	cation			· · · · · · · ·		10d. Inside C	ity Limits
	Ba-f e	Director	Maryland Saint Mary's Great Mi						1 🗆 Yes	2 <b>X</b> No
	with the	Dire	10e. Street and Number	10f. Zip Code		1	0g. Citizen of	What Cou	ntry?	
	Jeath ms 23	Funeral	21896 Chancellor Run Road  11. Marital Status   12. Was Decedent Ever in U.S.   13. V	20634 Was Decedent of His	panic Origin? (Sr	pecify Yes or No-	USA 14. Ba	ice - Ameri	can Indian,	
336	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "naturel", or liems 23a or 28a-f ehow other than "naturel", or liems 23a or 28a-f ehow event, the Medical Examinar must be notified at	by	1 Never Married 2 Married 1 □ Yes 2 K No	Was Decedent of Hisp If Yes, specify Cuban, 1 ☐ Yes 2 No	Mexican, Puerto Specify:	Rican, etc.)		ack, White,	etc.	
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an	0 - 0 5	To Be	George Webster Johnson		Eleanor			,		
Maryland 21215-0036	2 should be and Mental is marked (sumatic ev			ng Address <i>(Street an</i> Horse Head R			City or Town	n, State, Zij	Code)	
≥ ഗ്	fealth		John Edward Allgood, Jr. / Son Great 1  20a. Method of Disposition 20b. Place of Dispo	Mills, Maryl	and 20634					
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: if item 27 is marked any Injury or other traumatic a <u>once</u> .		1XXBurial 2 □ Cremation 3 □ Removal from State	natory or other place)		ember	20c. Location			
Ħ	mit. P partme portan injur.		Juseph St. Juseph	's Cemetery 2 Name and Address attingley-Ga			Morganza	, Mary	land	
m —	Per in De		michael Terra Hardine > P	.O. Box 270,	Leonardto	wn, Maryla	and 2065	0		
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о Е	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burtal-transit	Physicia		Other (specify)			М	onth	Day '	Year
٦.	res that the signed by be detac	y Ph	Part II. Other significant conditions contributing to death but not resulting in the ur	nderlying cause given	in Part I.	23e. Did tob	pacco use con	tribute to t	he cause of d	leath?
Records,	w requires been sign should be	Completed by	SUPERTENSION, DEMENTIN			1 □ Ye	s 2 No	3 🗆 Prot	ably 4	Unknown
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<u> </u>	Attending I death. ctor: After y the funer	atlo	1 Natural 5 Pending (Month, Day Year) Injury 2 Accident investigation		s 2 No		. ,			
Division of	el or Attending Physicien: s after death. i Director: After this certific id in by the funeral director,	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, streething building, etc. (Specify)	et, factory, office		28f. Location (Sti City or Town	reet and Num , State)	ber or Rura	al Route Num	ber.
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	Medical (	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death 2 Medical Examiner: On the basis of examination and/or invariant manner stated.	occurred at the time, restigation, in my opin	, date and place, nion, death occur	and due to the ca red at the time, da	use(s) and m ite and place,	anner as s and due to	tated. the cause(s	)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	29c. License n		29	d. Date signe	ed (Month,	Day, Year)	
				D199	17		11-16	-05		
AO;-	,	4	39 Name and address of person who empleted cause of death (Item 23a) (Type, I		Marris - 1	20610				
	Sta	tę	Dr. James C. Boyd, M.D. 2050 Wildewood Center, 31. Date filed (Month, Day Year) 32. Redistrar's Signature	, carriornia	, maryland	20013				
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4	Physici /Medio			yres							2. Date of De Month Novemb	aath Da	y Year		e of Death
	Examin Funeral	er	4a. Facility Name (If not institution, give s  Homewood At Crum  5. Social Security Number  6. Sex	land Farn	(In yrs.	last birthday)	If Unde	rede:	rick If Under 2 Hours	24 Hrs. 8	B. Date of Bir	rth ay, Year)		ick	ite or Foreign
	Director		579-22-4578  Usual Residence of Decedent  10a. State 10b. County			87 Yrs.	ocation			C	ct.18	,191	8   Ma	ryland	e City Limits
	the Mary 28a-f eh	Director	Maryland Frederic	k	Mi	ddleto		p Code				10a Cit	izen of What C	1気	/es 2 □ No
36	be filed within 72 hours after death with the Maryland Hygiene. d other than "natural", or iteme 23a or 28a-f ehow event, the Medical Esaminar must be notified at	by Funerai Di	1 Larch Lane 11. Marital Status 1 Never Married 2 Married 3  Widowed 4 Divorced	2. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give Year or Dates:		1	2	1769 Ident of Hi ocity Cuba	ispanic Orig n, Mexican, Specity:	jin? (Spec Puerto Ri	ify Yes or No ican, etc.)		USA 14. Race - Am Black, Wh	erican Indiar	1,
Maryland 21215-0036	within 72 hour lene. than *naturel tre Medical Ex	Completed b	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation	+)	life.	kind of we DO NOT u	ork done d ise retired	during most )		7		ind of Business	s/Industry	
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aryla		은	William R.  19a. Informant's Name/Relationship (Type	Willian De, Print)	ns	19b. Mailir	ng Addres	s (Street a	Bet and Number			er, City o	Koo r Town, State,		
ě,	1 and 2 Health a tem 27 is		John Hedges/Nephew  20a. Method of Disposition		20h F					nue			lle, MD		
Baltimore,	00		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	1	Place of Dispo cemetery, cren vnsvi11			1				ocation - City or		
Balt	permit. Page Department Important: If eny Injury o		21. Signature of Funeral Service License	N. Sta	us	he 16	2. Name a 521 0	nd Addres	s of Facility	Stau Pik	ffer F e. Fre	uner deri	alHome	, PA	
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DIVIS	To the Hospital of Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injurbuilding, etc.	ry - At ho (Specify	ome, farm, stre	eet, factor	y, office		281	Location (S City or Tow	Street and vn, State)	d Number or Ri	ural Route N	umber,
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,	To the comple	Me	29b. Signature and title of certifier  Michael S. Russ					License					signed (Mont		)
	7	-	30. Name and address of person who con	pleted cause of de	ath (Item	23a) (Type, I	Print)	-					, 20		
8	Star Registra		300 S CHURC 31. Date filed (Month, Day, Year) NOV 102	32. Replan	's Signa	ture	Land	m.	D,						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

22:10PM

10d. Inside City Limits

Black

Approximate Interval Between Onset and Death

1 Yes 2 No

DHMH 17 Rev 1/2001

State

Registrar

6,88 0 40 PN HILL RO # 701, OXON IFILL, MD 20745

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

NOV 0 9 2005

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Registrar's Signature

		1	State of N - State Registrar Amend#31.Per VR PGC	/laryland / Depa 11-8-05c <b>©e</b> r	artment of H	ealth and Me Death	ntal Hygiene	1 ( ) ( ) ( )	37888
**	gs. Fran		Registrar Atticition (First, Middle, Last)  1. Decedent's Name (First, Middle, Last)				. Date of Death		3. Time of Death
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	/Medic		4a. Facility Name (If not institution, give street and number		4b. City, Town, or			. County of Deat	
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	Funaral		5. Social Security Number 6. Sex 7.	Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs. 8	. Date of Birth	9. Birth	hplace (State or Foreign
	Funeral Director		220-92-6381 1□M 2⊠F	41 Yrs.	Months Days	J J	(Month, Day, Year, uly 10, 1	964 Was	sh, D.C.
			Usual Residence of Decedent						10d. Inside City Limits
	how		10a. State 10b. County	10c. City, Town or Lo	ocation				1⊠Yes 2□No
	a-f-	cto	Maryland Prince George	Lanham					
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	72 hours after death with the Maryland natural; or Iteme 23a or 28a-f ehow deal Examiner must be notified at	Funeral Director	9949 Goodluck Road					14. Race - Ame	
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36	or it		1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☐ If Yes, Give 1 ☐ Widowed 4 ☐ Divorced Year or Date		1 ☐ Yes 2 ☑ No	Specify:		Specify: B	Black
21215-0036	ural'	Completed by	3 Widowed 4 Divorced Year or Date		dent's Usual Occupa	ation		Kind of Business/	/Industry
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<b>q</b>	be filed within 72 hours after death with the Marylan ital Hyglene. ed other then "natural; or iteme 23a or 28a-f show event, the Madical Examiner must be notified at		17. Father's Name (First, Middle, Last)			18. Mother's Name (	First, Middle, Maide	n Sumame)	
an	id be ental ked c	To Be	Robert Brooks, Jr.			Mary The	eresa Bows	ser	
Maryland	s 1 and 2 should be fi Health and Mental H Itam 27 is marked of other traumatic ever	-	19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (Street	and Number or Rural	Route Number, City	or Town, State, 2	Zip Code)
	7.2 mg		Brian R. Smith, Sr./Spous	se 2130	Alice Ave	. #1: Oxor	n Hill, MI	2074	5
ନ୍	of Heal Itam 2 other		20a. Method of Disposition	20b. Place of Dispo		Da		ocation - City or	
10	ages ent of nt: If		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from Sta 4 ☐ Donation 5 ☐ Other (Specify)	Mt. Olive			005 Was	hington,	D.C.
Baltimore,	permit. Pages of Popartment of Himportent: If Its eny injury or of pages.		21. Signature of Funeral Service Licenses	11/1/2	2. Name and Addres	ss of Facility Pol	ge Funeral	Homes	
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æ	The lav	Completed					performed?	death?	
Vital	sician: The certificete ha	0	25. Was case referred to medical			26. Place of Death	Check only one		
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οl			27. Manner of Death 1 ☑Natural 5 ☐ Pending 28a. Date of (Month,	Injury 28b. Time Day Year) Injury	of 28c. Injui	ry at 2.	8d. Describe how in	ury occurred	
Division	death. ctor: Af y the fur	Certification:	2 Accident investigation	1	M 1 🗆	Yes 2 No			
<u>×</u>	for Attendate after death Director:	tific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place o building	f Injury - At home, farm, s g, etc. (Specify)	treet, factory, office	2	8f. Location (Street a City or Town, Sta	and Number or R Ite)	Rural Route Number,
	tato rs aft al Di	Cer				10.0			
	tospi toner uner	cai	29a. Certifier (Check only 2 Medical Examiner: On the bas	is of examination and/or i	ath occurred at the ti investigation, in my o	me, date and place, a opinion, death occurre	nd due to the cause d at the time, date a	(s) and manner a nd place, and du	is stated. le to the cause(s)
	To the Hospital or Attending within 24 hours aftar death. To the Funeral Director: Afte completaly filled in by the fune	Medicai	one) and manne	r stated.	29c, Licens	se number	29d F	Date signed (Mon	ith, Day, Year)
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R	(6)		30. Name and address of person who completed cause	of death (Item 35a) (Type	Print) m/	2177	L Torons	ta Forre	er Estoye,MD.
/ [**			31. Date filed (Month, Day, Year)	gistrar's Signature	1110	20//	Tieresi	ra relle	or notoye, m
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Karl Burrell, Sr. State of Maryland / Department of Health and Mental Hygiene 1- State of Maryland / Department of Health and Mental Hygiene 1- State of Maryland / Department of Health and Mental Hygiene 1- State of Maryland / Department of Health and Mental Hygiene 1- State of Maryland / Department of Health and Mental Hygiene 1- State of Maryland / Department of Health and Mental Hygiene 1- State of Maryland / Department of Health and Mental Hygiene 1- State of Maryland / Department of Health and Mental Hygiene 1- State of Maryland / Department of Health and Mental Hygiene 1- State of Maryland / Department of Health and Mental Hygiene 1- State of Maryland / Department of Health and Mental Hygiene 1- State of Maryland / Department of Health and Mental Hygiene 1- State of Maryland / Department of Health and Mental Hygiene 1- State of Maryland / Department of Health and Mental Hygiene 1- State of Maryland / Department of Health and Mental Hygiene 1- State of Maryland / Department of Health and Mental Hygiene 1- State of Health Albert / Department of Health and Mental Hygiene 1- State of Health Albert / Department of Health Albert / Department of Health Albert / Department / D 05-07401 crn 1. Decedent's Name (First, Middle, Last) Karl Burrell, Sr. Karl Ervin Burrell 2. Date of Death Physician November 03, 2005 7:50 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 2401 Southern Avenue, Apartment 101 Prince George's Temple Hills If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 ₹ M 2 □ F 217-60-5617 52 Director 03/03/1953 Washington, DC Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow r than "natural", or itema 23a or 28a-f ahov the Medical Examiner must be notified at Y⊟Yes 2 No Director MD PG Capitol Heights 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 4905 Fable Street 20743 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after Almed Folces: 1√2 Yes 2 □ No If Yes, Give Year or Dates: 71 – 72 1 Never Married 20 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Black Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Construction Private permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy Importent: If item 27 is marked ofth any injury or other traumatic event, 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Joseph Burrell Ruby Jenifer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6006 Springhill Drive; Greenbelt, MD 20770 LaKesha K. Chase - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD Veteran Cemetery 11/10/2005 Cheltenham, Maryland Funeral Service Licentee 22. Name and Address of Facility Freeman Funeral Services 21. Signature P.O. Box 416; Suitland, Maryland 20752 Part 1. Enter the disease, or combilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Hypertensive Atherosclerotic Cardiovascular Disease /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off: Examine sicien and e burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Records, P.O. Box 68760. Physician/Medical attending physic IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1) Yes 2 \[ \subseteq \text{No} \] 24a. Was an autopsy performed? Yes 2 \( \square\) No Yes Division of Vital 25. Was case referred to medical examiner?
1 X Yes 2 □ No Be director 26. Place of Death | Check only one Hospital: Other 4 Nursing Home 5 Residence 6 Hother (Specify) at scene 1 ☐ Inpatient 2 ☐ ER/Outpatient 2 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: 1 X Naturat 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death Diractor: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. November 04, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 RUBIO, MD ANA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 1 5 2005

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend#9a.Per Informt.Pg 11-15-05 cr State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amend# 26.Per Phys.PGC cr Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month / 02/2005 **Physician** JANNIE J. 8:30A M BOWDEN /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7807 Powhatan Street New Carrollton Prince Georges If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 01/1/19/ 9. Birthplace (State or Foreign Country) 1923 Eagle Sorings 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□M 2X F 82 244-46-4602 Yrs Director Springs NC Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 XYes 2 No MD Prince Georges New Carrollton Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 7807 Powhatan Street 20784 23a USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or items 11. Marital Status 2 should be filed within 72 hours after and Mental Hygiene. 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Black ģ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+)
2 vears Elementary/Secondary (0-12) years House Wife Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Important: If item 27 is marked oth any injury or othar traumatic event Oscar Jackson Anne Jackson Jaa Informant's Nama/Belationship (Type, Print)
Shirley Bowden
Shirley Jackson / Daughter 195 Mailing Address (Street and Number or Rural Boute Number, City or Town, State, Zip Code) New Carrollton, MD 20784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☑ Aremation 3 ☐ Removal from State 11/07/2005 Harmony Memorial Landover, MD 1 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Reese Professional Funeral Service 3605 14th St., NW Washington, DC 20010 eral sen ce Li 21. Signatur 23a. Part1. Enter the disease, or composhock, or heart failure. List only deations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ereb MACU disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine death certificate be executed use as the burial-transit that initiated events resulting in death) Last the attending physician and Due to (or as a consequence of): Box 68760 Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy ίο in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performed? certificate 2 □ No 1 ☐ Yes 2 No 1 TYes Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 3□ DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation M hours after death. filled in by the Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours af To the Funeral D 29a. Certifier Tigocertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) Registrar's Signature State

Registrar

NOV 1 0 2005

			For State Registrar	State of Ma	arylar				lealth a Death		, ,		200	5	37891
	Physicia		1. Decedent's Name (First, Middle,	Last)							2. Date of Dea Month		Ye	-	3. Time of Death
	/Medic			ara S. Brown	1						Novembe	er 4	200	05	12:00P M
4.	Examin	er	4a. Facility Name (If not institution,  Prince Geo-	gwe street and number) rge's Hospit	ta1		4b. City,	lown, or	Cheve			4c. (	County of D		George's
er.	Funeral	-		5. Sex 7. Ag		last birthday)	If Under		If Under	24 Hre	8. Date of Birth	Vans			ace (State or Foreign
6	Director		578-42-8518	1 □ M 2 🔼 F	7	74 Yrs.	Months	Days	Hours	Min.	June $12$ ,	19:	31		sh., DC
	and w		Usuel Residence of Decedent  10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							10	d. Inside City Limits
	Mary!	ţō	Maryland Prince	e George's			Uni	ner N	Mar1b	oro					1X Yes 2 □ No
	th the or 28s	lrec	10e. Street and Number	000180			10f. Zip		TGT TO	OLO	1	0g. Citiz	en of What	Count	ry?
	ath wi	ralD	13101 Water							774			United		
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Incortant: if item 27 is marked other then *netural; or Items 23a or 28a-f show my njury or other traumatic event, Ita Mydical Exacultier mail to inclified at 201.	Funeral Director	11. Marital Status  1 Never Married 2 Marrie	12. Was Decedent Armed Forces? d 1 ☐ Yes 2 🔯		1				gin? (Spe 1, Puerto i	cify Yes or No- Rican, etc.)		4. Race - A Black, W	merica hite e Af 1	in Indian, tc. cican
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tim	t. Pag tment rtant: njury o		4 □ Donation 5 □ Other (Spe	ecify)	Mt	. 01iv					4/2005 :ewart F		ash.,		
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Вох	death certifica e attending pt of for use as ti	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			JEctopic pi	regnancy				2:	3d. Date of		,
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			fleat	Wall of the	,				D0026	5024		No	vembe	r 7	, 2005
2	(8)		30. Name and address of person w	no completed cause of dister Miles,				lover	Rd.,	Sui	te F.,	Land	lover,	MD	20785
F	Sta Registr		31. Date filed (Month, Day, Year) NOV 1 0 21	Registr	ar's Sign	ature	D								

State of Maryland / Department of Health and Mental Hygieney 1 - For Stete Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Edna Ruth Clem November 17 2005 0200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 348 Ed Moore Road Elkton Ceci1 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1□M 2√F Yrs. Director JAN 14, 212**-**30-1104 Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a, State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or Items 23a or 28a-f show any injury or other traumatic event, Item Madical Examinat mail te notified any injury or other traumatic event, Item Madical Examinat mail te notified a 10d. Inside City Limits Directo 1 ☐ Yes 2 🕅 No Maryland Ceci1 E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 348 Ed Moore Road 21921 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No þ Specify: 3 Widowed 4 X Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Convenience Stores 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Formie Thomas Bea Cimabue 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Denise C. Warrington/Daughter 360 Ed Moore Road, Elkton, Maryland 21921 20b. Place of Disposition (Name of cemetery crematory or other place)
Immaculate
Conception Cemetery 20a. Method of Disposition November 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 19, 2005 Cherry Hill, Maryland ,22 Name and Address of Facility. Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, Maryland 21921 21. Signa ure of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Conjustice /Medical Due to (or as a consequence of) **Examiner** Due to (or as a c ps quence of): Sequentially list conditions, if any, leading to immediate cause. Enter the driping Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-transit Dali melle Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 □Ectopic pregnancy 1.☐Live birth in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 3 Probably 4 Unknown 1 Yes 2 No Completed 24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death Check on one Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 ☐ Yes 2 No this Manner of Death

Natural

Accident funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After To the Hospital or Attanding 5 Pending after death. 1 🗌 Yes 2 No investigation in by the 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide within 24 hours a To the Funeral C 1 Pertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number our ece lus 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) west main st 31. Date filed (Month, Bay, Year) State Registrar

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i.			<ul> <li>State Registrar Amend#4a . Pet</li> <li>Decedent's Name (First, Middle, Las</li> </ul>		-05 <b>cre</b> i	TITICE	ite of L	Jeath	2	Date of Deat	eg. No.C	2005	3 / 8 9 3 3. Time of Death
	Physici		Felton Braswell		ton					Month October	Day	Year 2005	6:50 p M
	/Medio		4a. Facility Name (If not institution, give Southern Maryland Southern Maryland	sizeer and number) Sub Acute Cer l-Hospital	nter		y, Town, or inton	Location of			4c. C	county of Deat	h
	- Funeral		5. Social Security Number 6. Se				ler 1 Year	If Under 2 Hours	24 Hrs. 8. Min.	Date of Birth (Month, Day,			hplace (State or Foreign untry)
	× Director		244-20-0808 Usual Residence of Decedent	81	Yrs.				Ма	rch 10	,192	24 Nort	h Carolina
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9	or Ite	by Funeral Director	1 Never Married	Armed Forces? 1 ☐ Yes 2 XX0 If Yes, Give	1		Decity Cuba	n, Mexican, Specify:	, Puerto Ric	an, etc.)		Black, White Specify: B1.	
21215-0036	within 72 hours after death with the Maryland ene. then "natural", or Iteme 23a or 28e-f ehow ha Medical Examine mast be notified at	d b	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Ed	Year or Dates:			sual Occupa					d of Business/	
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Ma	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Importement of Health and Mental Hygiene. Importement if item 27 is marked other then "natural", or Iteme 23a or 28e-1 e how any injury or other traumatic event, the Medical Examinetment be natified an applical.		Velma Carrington	/ Wife						Hills,			
Baltimore	iges 1 and of He		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐		Place of Dispo cemetery, crer .coln Mo	sition (A matory o	iame of r other place	9)	Date	9		ation - City or	Town, State
ţim	rtment rtent: njury o		4 ☐ Donation 5 ☐ Other (Specify			Maryland							
Bal	permit. Pa Departmer Importent eny injury once.		21. Sign stury of Funeral Cervice Licen	Forest	vill	es P.A.	20747						
172	Physician		23a. Part1. Enter the disease, or comp shock, or beart failure. List only of Immediate Cause (Final	lications that caused the dear	th. Do not ent	er the m	ode of dying	g, such as o	cardiac or re	espiratory arre	est,		Approximate Interval Between Onset and Death
	_/Medical		disease or condition resulting in death)	a. Due to de as a consec	uence of):	100	776	TIM	UDF	AM	4		
÷ 3	Examiner	L	Sequentially list conditions,	b	UN,	101	_						
	petr lusit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	quence or):	-	A	-12	de				
oʻ	be executed icien and burial-transit	Еха	that initiated events resulting in death) Last	Due to (or as a consec	quence of):	~,	)	1 1 1	6.10				
8760,	ate he y	dicai	(	d		77	+	·					
9	eath certifica attending ph for use as t	√Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregn	ancy						22	3d. Date of deli	vec.
Box	the attendin	Physician/Me	in the past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c 9 ☐ Unknown		Ectopic Other	pregnancy (specify)					Month	Day Year
P.0	that the de ed by the detached	Phys	9 Unknown										
ds,	signed be del	5	Part II. Other significant conditions co	with butting to death but not res	suiting in the ui	naeriying	g cause give	nın Parti.			s 2 🗆		the cause of death?
of Vital Records,	w requir been s should	Completed								24a. Was a			topsy findings available
Re	The lay te has age 2	omp			·					autops perforn	y	death?	topsy findings available completion of cause of 2 No
ital		BeC	25. Was case referred to medical examiner?					26. Place	of Death (C	1 ☐ Yes 2 Check only on		1 1 165	2010
<u>&gt;</u>	Physiclan: this certific ral director,	၉	1 □ Yes 2 No		ER/Outpatien			4 🖭 1901	rsing Home	5 🗆 Reside	nce 6	□Other (Spec	cify)
Suc	ding P	ilon:	27. Manner of Death  1 Death  5 Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	f M	28c. Injury Work	at ? Yes 2 N		I. Describe ho	w injury	occurred	
Division	il or Attending after death. Director: After I in by the fune	ficat	3 Suicide 6 Could not be	286. Place of Injury - At h	ome, farm, str			163 2 11		Location (St	reet and	Number or Ru	ral Route Number,
Ö	9 4 5 5	Certification:	4 Homicide	building, etc. (Speci	<i>fy)</i>					City or Town	, State)		1
	Hospital 24 hours a Funeral I	Medical	29a. Certifier Certifying Phyone)	rsician: To the best of my kno	owledge, death	h occurre vestigati	ed at the tim on, in my op	e, date and pinion, death	d place, and h occurred :	I due to the ca at the time, da	ause(s) a ate and p	nd manner as lace, and due	stated. to the cause(s)
	To the h within 24 To the f complete	Med	29b. Signature and title of certifier	and mariner stated		2	9c. License	number -	30	-7 2	9d. Date	signed (Montt	n. Day, Year)
	7		) / m			2	) OC.	DX	10	0/6	0/	311	2001
0	(5)	ı	30. Name and address of person who c			Print)	AM	17	50	0)			
	0.		31. Date filed (Month, Day, Year)	37. Registrar's Signa		15			OCM	`/, W		<del></del>	
	Sta Registr		NOV 0 8 200°		. 1								

			For Stata Registrar	State o	f Marylar		artment of H		lental Hygie	21115	37894
7	A 80		Decedent's Name (First, Middle,	Last)					2. Date of Death		3. Time of Death
	Physici /Medic		Robert Camp	bell						Day Yea	2005 10:21 1
	Examin		4a. Facility Name (If not institution,		mber)		4b. City, Town, or	r Location of Death		4c. County of De	
4.		î	Washington Ad				Takoma			Montgor	nery
4	Funeral Director		240-80-8446	.Sex 1 <b>X</b> M 2 ☐ F	7. Age (In yrs. 5 7	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye 08/09/1	iar)	Birthplace (State or Foreign Country) NC
	and		Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation				10d. Inside City Limits
	Maryl f sho	jo	DC		W	ashin	aton				1 □X(es 2 □ No
	28a	Director	10e. Street and Number				10f. Zip Code		10g.	Citizen of What	Country?
	h with	D IE	919 L Street	NW			200	001		USA	A
98	d within 72 hours after death with the Maryland jiene. r than "natural", or iteme 23a or 28a-1 show the Medical Exeminar must be notitied at	y Funeral	11. Marital Status 1 ☐ Never Married 2 🖾 Married	Armed Fo	2√ No		Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Span, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ar Black, WI Specify:	
21215-0036	hours tural',	ed by	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's	Year or D	ates:		dent's Usual Occup		161	. Kind of Busines	
215	within 72 ene. than "na	Completed	(Specify only highest : Elementary/Secondary (0-12)	grade completed)	1.40(5)	(Give	kind of work done of DO NOT use retired	during most of work	ing	i. Kind of busines	ss/industry
212	giene.	mo:	12	College (	1-401 3+)	Buil	ding Ma:	intenanc	e 1	Real Es	state
pu	be filed tal Hygie d other	Be (	17. Father's Name (First, Middle, La	st)				18. Mother's Name	(First, Middle, Maid	den Sumame)	
yla	should be ind Mental marked o umatic eve	P	Harlee Campbe						Gillesp:		
Maryland	C1 00 = 0		19a. Informant's Name/Relationship			19b. Mailir	$\overset{\text{ng Address }(Street)}{19}\overset{\text{ng Street}}{L}\overset{\text{street}}{\mathbb{S}}\overset{\text{street}}{\mathbb{S}}$	and Number or Rura reet NW	al Route Number, Ci	ty or Town, State	, Zip Code)
	1 and Health em 27		Barbara Campb 20a. Method of Disposition	err- w		Place of Dispo	ashington sition (Name of	on, DC 2	0001 Pate 200	. Location - City	or Town State
JOIL	ages ant of nt: If it y or o		1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		State	cemetery, crei	matory or other plac	1	L	aurel	Hills
Baltimore,	permit. Pages 'Department of P Important: If ite eny injury or ot		21. Signature of Funeral Service Lice	• •	) RO	$\frac{22}{L}$	on_Cemet 2. Name and Addres atney's	ss of Facility	$06/05 _{ m No}$		ralina 7e., N.W.
	40200		23a. Part 1. Enter the disease, or co	omplications that of	caused the deal	F	uneral :	Home V	Washingt	on, DC	20011 Approximate
*	*		shock, or Neart failure. List or tmmediate Cause (Final	lty one cause on e	each line.			g, such as cardiac c	n respiratory arrest,		Interval Between Onset and Death
2"	Physician /Medical		disease or condition resulting in death)		(or as a consec		Lghanu	1			
П	Examiner		O WAR TANK THE	50010	(01 43 4 0011300	(defice of).	0	/			
	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to	(or as a consec	justice of):					
	ecute and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to	(or as a consec	uanca of):					
68760,	cate be executed physicien and ; the burial-transit	alE			(01 43 4 0011300	puorice (1).					
687		edical		d							
P.O. Box	that the death certificated by the ettending produced for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live b	tcome of pregna birth 2 Feta nant at time of c own	ıl death 3 [	Ectopic pregnancy Other (specify)			23d. Date of d Month	elivery Day Year
	res that igned b	by Pt	Part II. Other significant condition	s contributing to de	eath but not res	sulting in the u	nderlying cause give	en in Part I.	23e. Did tobacc	o use contribute	to the cause of death?
rds	w require been slg should b		Gastro Antest	nal Be	ud				1 🗆 Yes	2 No 3 2	<sup>6</sup> robably 4 □Unknown
Division of Vital Records,	hes hes	Completed							24a. Was an autopsy performed	? prior to	autopsy findings available completion of cause of
ita	icien: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?					26. Place of Death			22.10
) t	Physicien: r this certific ral director.	၉	1 ☐ Yes 2 🔀 No			ER/Outpatien		4   Nursing Hor	me 5 Residence	6 □Other (Sp	pecify)
חכ	ling After Tune	ion:	27. Manner of Death 1 Matural 5 ☐ Pending		of Injury th, Day Year)	28b. Time of Injury	Work		28d. Describe how in	njury occurred	
isi	or Attending after death. Director; After in by the fune	flcat	2 Accident investigat 3 Suicide 6 Could no	ho	of Injury - At h	ome, farm, str		Yes 2 □ No	28f. Location (Street	and Number or	Rural Route Number.
<u>S</u>	al or / s atter il Dire	Certification:	4 Homicide	buildi	ng, etc. <i>(Specil</i>	(y)	eet, factory, office		City or Town, St		Taran Progress Warners,
	To the Hospital or Attend within 24 hours after death To the Funeral Director; completely filled in by the	Medical (	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	ammer; On the b	best of my kno asis of examina ner stated.	owledge, death ation and/or in	n occurred at the time vestigation, in my of	ne, date and place, a pinion, death occurr	and due to the cause ed at the time, date	e(s) and manner a and place, and di	as stated. ue to the cause(s)
	To the within To the comp	W	29b. Signature and title of certifier	11 a. L	idical	Drove A	29c. License		29d.	Date signed (Mo	nth. Day, Year)
)			Jalyaseun	min, .~				3403		ul03/0	
2	(10)		30. Name and address of person with SAGYNBALLY W		se of death (Iter	п 23а) (Туре,	Print) Take	LARROW LA BARK,	MARYLA	e ND-2	0912
Y	Sta Registr	_	31. Date filed (Month, Day, Year)  NOV 1 0 2	005 R	legistrar's Signa	ature do	will service				
	3 4		ILAA Y A P.								

			1 - State Registrar	State of Ma	-			nt of He te of D		and M	, ,	jiene	Prop.	270	0 =
- 1	Physici	ian	Decedent's Name (First, Middle, Las.     Nils	)							2. Date of Dea Month Novembe	th	Year	3. Time o	Death P M
	/Medic Examin		4a. Facility Name (If not institution, give			Ua	4b. City	Town, or I		f Death	Novembe	4c. County Mont	of Death	3:00	P
1	Funeral Director	× ,	Shady Grove H  5. Social Security Number 100-03-2180		e (In yrs. last bir 90	thday) Yrs.	If Unde Months	r 1 Year	If Under:		8. Date of Birth (Month, Day Nov. 18	Year)	9. Birthp Coun	lace (State	or Foreign
	death with the Maryland me 23a or 28a-f ehow rmust be notified at	ai Director	Usual Residence of Decedent  10a. State Md. 10b. County Mon.  10e. Street and Number 9701 – Veirs D		10c. City, Tow	n or Lo	F	Rockv	/ille	9		10g. Citizen of W US A	/hat Coun		ity Limits 2 □ No
0500-61717	d within 72 hours after death with the Marylan Jiene. r than "neturel", or iteme 23s or 28s-1 ehow The Madical Examiner must be notified at	leted by Funeral	11. Marital Status  1 Never Married 2 Married  3 XWidowed 4 Divorced  15. Decedent's Ed		nknown	Deced	Yes, spe	orfy Cuban	Specify:	, Puerto	ecify Yes or No- Rican, etc.)		k, White, Wh	ite	
	be filed within tal Hygiene. Id other then event, the M	Be Completed	Elementary/Secondary (0-12)  12  17. Father's Name (First, Middle, Last) Thure Carlsor	College (1-4or 5	5+)			ntant	18. Mothe		(First, Middle,	ACCOL		ng	
Maryland	d 2 should th and Men 7 is marks traumatic	To	19a. Informant's Name/Relationship (7 Kristina Hughes	ype, Print)					nd Numbe	r or Rura	Stahl  Rockvil			Code) 850	
saitimore,	Pages 1 annent of Heali ant: if Item 2 arry or other		20a. Method of Disposition  1 Burial 2 XCremation 3 4 Donation 5 Other (Specify		20b. Place of	f Dispo:	sition (Na	me of	10			20c. Location -	City or To	wn, State	/a.
Balt	permit. Page Department of important: if any injury or		21. Signature of Funeral Service licenta	The state of			TT	nd Address	7.0	Twa	, NW , Wa	ash.,DO	7		
8/60,	Cate be executed /Medical Examiner ithe burial-transit	dicai Examiner	shock, or heart failure. List only(c) Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	a consequence	of):	a the mo	ue or dying	, sucii as	carulac	л гөэргасогу агг	est,		Approxima Interval Bei Onset and	tween Death
O. Box 6	the death certifi y the attending tched for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death		Ectopic p	pregnancy pecify)				23d. Date Mor			Year
7	The law requires that ite has been signed b age 2 should be deta	Ď	Part II. Other significant conditions co	entributing to death b	ut not resulting i	n the ur	nderlying	cause giver	n in Part I.		23e. Did to	bacco use contri es 2,2 No		e cause of dably 4 🗍	
Vital Hecords,		Completed									24a. Was a autops perior 1 Yes	sy p med? d	Vere autor rior to con eath? Yes	psy findings npletion of c 2 2 No	available cause of
ō	Phy this ald	ation: To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	Hospital: 1 Inpatie 28a. Date of Inju (Month, Da		tpatien Time of Injury		OA Other 28c. Injury Work	4 □ Nu	rsing Hor	n (Check only or me 5 ☐ Reside 28d. Describe h	ence 6 □Othe		)	
DIVISION	Hospital or Attending 44 hours after death. Funeral Director: After tely filled in by the funer	Certification:	3 Suicide 6 Could not be 4 Homicide determined	building, et	c. (Specify)						28f. Location (S City or Town	n, State)			nber,
	To the Hospital within 24 hours of the Funeral completely filled	Medicai	29a. Certifier (Check only one)  1 Certifying Physical Example one)  1 Certifying Physical Example one)  2 Medical Example one)	rsician: To the best iner: On the basis o and manner sta	r examination an ated.	id/or inv	estigation 29	n, in my api	nion, deal	th occurr	ed at the time, d	ate and place, a	nd due to	the cause(s	s)
3	(5)		30. Name and address of person who d	ompleted cause of d	leath (Item 23a)	(Type, I	Print)	63	26	3		Novem	085	6,20	205
		ate	Hakim Morsli 31. Date filed (Month, Day, Yeer) NOV 1 0 2065	9901 M	edical ar's Signature	Lan	nter	pr	ive	Roc	kville,	MD:	2085	0	
Syc.	Regist	rar	MONT O COO	Deleve	10 14	AL PARTY									

				ate of Marylar	nd / Depa	artment c	of Health a	•		ne	
			1 - Stete Registrar		Cei	rtificate	of Death		Reg. I	2005	37896
***	Physici	an	Decedent's Name (First, Middle, Last)  Locarb Name (Control	. T.,				Mon		ay Year	
	/Medic Examir		Joseph Walter Carter  4a. Facility Name (If not institution, give street			4b. City, Tov	vn, or Location of			16, 2005 tc. County of De	
		*	40425 Kavanagh Rd.			Mecha	nicsvill	Le	5	Saint Ma	ry's
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. 2□ F		If Under 1 Y Months D	ear If Under 24 ays Hours	Min. (Mor	of Birth oth, Day, Yea	9. Bi	rthplace (State or Foreign country)
٧	Director		219-34-4818 Usual Residence of Decedent	6	6			Octob	er 26,	1939 Mar	yland
	aryland show	٤_	10a. State 10b. County	10c. Ci	ty, Town or Lo	cation					10d. Inside City Limits
	be Ma	ecto	Maryland Saint Mary'	s Me	chanics						1 ☐ Yes 2X ☐ No
	with t	by Funeral Director	10e. Street and Number 40425 Kavanagh Rd.			10f. Zip Co			10g. (	Citizen of What C	Country?
	death ms 2%	nera	11. Marital Status 12. W	as Decedent Ever in U	.S. 13.		of Hispanic Origi Cuban, Mexican,	in? (Specify Yes	or No-	USA 14. Race - Am	
စ္တ	or Ite	y Fu	1 Never Married 2 Married 1	med Forces?  Yes 2 XNo Yes, Give	1	r Yes, specity i 1 □ Yes 2 🎇		Puerto Rican, e	tc.)	Black, Wh	
21215-0036	within 72 hours after death with the Maryland ene. then "natural", or Items 23e or 28e-f show he Medical Examinar must be notilised at	ed b		ear or Dates:		dent's Usual O			104	Specify: B	
215	hin 72 In "na Medic	Completed	(Specify only highest grade corr	ollege (1-4or 5+)	(Give	kind of work di DO NOT use re	one durina most d	of working	160.	Kind of Business	sylnaustry
7	ed wit ygiene ygiene rer the	Com	12	(1-401 54)	Cloth	es Pre				y Clean	ers
and	ntal H	Be	17. Father's Name (First, Middle, Last)  Joseph Walter Carter	C 20				s Name (First, A			
Maryland	should nd Me mark matic	P P	19a. Informant's Name/Relationship (Type, P	•	19b. Mailin	a Address (St.	reet and Number	Geneie			Zin Code)
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28e-f ehow eny Injury or other treumatic event, the Medical Examinar must be notified at once.		Glyceria Cecelia You		21470	Fores	t Run Dr	. Lexin	gton P	ark MD	20653
Baltimore,	of He of He If item or oth		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ Remov		Place of Dispo cemetery, cren	sition (Name o	of place)	Date	20c.	Location - City o	r Town, State
Ē	t. Pag rtment rtant: njury		4 □ Donation 5 □ Other (Specify)		rles Men			ov. 22, 20	005 Lec	nardtow	n, MD
Ba	permi Depa Impo eny Is		21. Signature of Funeral Service Licensee	Had S		Mattingl	ddress of Facility ey-Gardine	r Funeral	Home,	P.A.	
	24		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cau	ns that caused the teat			270, Leon dying, such as ca			0	Approximate
	Physician		Immediate Cause (Final disease or condition	Paulnop	tro.	Can	cei				Interval Between Onset and Death
- \$1 	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):						
ě		e.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseq	uence of):						
	uted d ansit	Examiner	Cause Enter Underlying Cause (Disease or injury that initiated events								
760,	ite be executed ysician and ne burial-transit		annulaine in denath) à nue	Due to (or as a conseq	uence of):						
00	P S S	dlcal	d.								
9 X C	leath certific attending p	/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If	yes, outcome of pregna	incy					22d Data of da	lives
O. Box	death e atte	Icla	in the past 12 months?	Live birth 2 Feta Pregnant at time of d		Ectopic pregna Other (s <i>pecif</i> )				23d. Date of de Month	Day Year
о. О	res that the de signed by the a be detached f	Physician/Med	9 🗆 Onknown	Unknown							
ďs,	law requires that the death certifics as been signed by the attending ph. 2 should be detached for use as the strong of the should be detached for use as the strong should be detached for use as the should be detached for use as the strong should be detached for the should be detached for t	by	Part II. Other significant conditions contribut	ling to death but not res	ulting in the ur	iderlying cause	given in Part I.	23e.	Did tobacco		o the cause of death?
000	w require been sig	Completed									
Division of Vital Records,	The law ate has page 2:	ошо							Was an autopsy performed?	death?	utopsy findings available completion of cause of
<u>=</u>	ysician: The is certificate hadrector, page	BeC	25. Was case referred to medical examiner?				26. Place of	f Death   Check	Yes 25 N	o 1L Yes	2 X No
5	두 두 등	2	1 ☐ Yes 2 ☐ No Hospita	1   Inpatient 2	ER/Outpatient	30000				6 ☐Other (Spe	ecify)
u O	ding F th. After funera	tlon:	- Gartenaria	a. Date of Injury (Month, Day Year)	28b. Time of Injury		njury at Work? 1 ∐ Yes 2 ∐ No		cribe how inj	ury occurred	
NISI	of or Attendi	ifica	3 Cuiside 6 Could not be	e. Place of Injury - At ho	ome, farm, stre			28f. Loca	tion (Street a	nd Number or R	ural Route Number,
בֿ	rs afte el Dir	Certification;	4   Homicide	building, etc. (Specify	V)			City	or Town, Sta	re)	
	To the Hospitel c	edical	29a. Certifier (Check only one)  1 Certifying Physician 2 Medical Examiner: C	t: To the best of my kno on the basis of examina and manner stated.	wledge, death tion and/or inv	occurred at the estigation, in n	e time, date and p ny opinion, death	place, and due to occurred at the	o the cause( time, date ar	s) and manner as	s stated. e to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	no mariner stated.	_		ense number		29d. D	ate signed (Mont	h, Day, Year)
			1 990	nu	)	H	00557	51	/	1-17-08	5
N			30. Name and address of person who complet			,					
	Sta	le.	Archana Gupta, M.D., Phil 31. Date filed (Month, Day, Year)	32. Rystrar's Signa	ture		035 Three	Notch Rd,	Hollyw	ood MD 206	536
	Registr	ar	31. Date filed (Month, Day, Year) NOV 1 8 2005	Lieu	N A	med o					

		State of Maryland / E		rtment of He		nd Me	_	ene () (	05	37897
Physici	ian	1. Decedent's Name (First, Middle, Last)  CATHERINE I. CRESS					Date of Death Month Ovember	Day	Year 005	3. Time of Death 5:30 A M
/Medi		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of		Ovember	4c. Count		J.30 A
Examir	ner	National Lutheran Home		Rockville					gomer	У
Funeral		Social Security Number     6. Sex     7. Age (In yrs. last bird.)	hday)	If Under 1 Year	tf Under 2	4 Hrs. 8.	Date of Birth			place (State or Foreign
Director		208-07-2200 1□M 2KDF 96	Yrs.	Months Days	Hours	0	(Month, Day, 2/25/19	09		sylvania
pg &		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town	n or Lo	cation					1	0d. tnside City Limits
ith the Marylar or 28e-f ehow	5	MD Montgomery Wheaton								1 ☐ Yes 2X No
28e-i	ect	10e. Street and Number		10f. Zip Code			10	g. Citizen of	What Cour	ntry?
3e or	0	1518 Crest Road		20902				U.S	Α.	
death	Funeral Director	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Decedent of His Yes, specify Cubar	spanic Origi	in? (Specif	y Yes or No-		ce - Americ	
or ite	F.	1 Never Married 2 Married 1 Yes 2 M No		☐ Yes 2X No	Specify:	FUBILO MIC	AII, 6(C.)		ck, write, y: Whi	
iled within 72 hours after death with the Maryland Hygiene. Whysiene. Whysical Exemities 23e or 28e-fehowent, the Medical Exemities much be incitified at	d by	3 Wildowed 4 □ Divorced Year or Dates:								
nat nat	iete	15. Decedent's Education 16a. (Specify only highest grade completed)	(Give	lent's Usual Occupa kind of work done di DO NOT use retired)	urina most d	of working	1	6b. Kind of B	iusiness/in	dustry
within them	Completed	Elementary/Secondary (0-12) College (1-4or 5+)		aker			0	wn Hom	e	
Hyg other	0	17. Father's Name (First, Middle, Last)			18. Mother	's Name (F	First, Middle, M.	aiden Sumai	ne)	***************************************
uld be Aenta rrked tic ev	0 8	Unknown			Unkn	iown				
2 sho and h is ma		1 1 1		g Address (Street a						Code)
and and m 27				Crest Roa	id, Wh					
2 2 2 3 3 5 3 5 5 5 5 5 5 5 5 5 5 5 5 5		1 Rurial 2 M Cremation 3 Removal from State cemeter	y, cren	sition (Name of natory or other place		Date	_	Oc. Location		
it. Partimentiment	Ų.	4 □Donation 5 □ Other (Specify) Ft. Lii 21. Sprature of Funeral Service Licensee		In Cremato					ood, I	Maryland
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mandal Hygiene. Important: if item 27 is marked other then "natural, or items 23e or 28e-1 ehow any nighting other treumatic event, the Medical Exempler mank be insufficed at once.		21. Squature of Pullera Bentice Censee		. Name and Address		-			ervla:	nd 20852
	30.71			er the mode of dying					11 ) 14.	Approximate
Physician		shock, or heart faiture. Litt only one cause on each line.	#1TOV						1	Interval Between Onset and Death
/Medical		disease or condition resulting in death)  PLEUR DL ET  Due to (or as a consequence or constitution)		ION						
Examiner		Sequentially list conditions b. CONGESTIVE	11	EMART F	ALLU	PE				
p ii	iner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury	zf)r							
be executed ician and burial-transit	Examin	Cause (Disease of Injury that initiated events resulting in death) Last  C. ADV AT M  Due to (or as a consequence of		ZH1: 1-1	r bi	LINE	N A.		-	
be executed sician and burial-transit	al E	500.10 (5) 20 20 51 100 (40)	,.							
icate h	edical	d								
The law requires that the death certificate the has been signed by the attending physicage 2 should be detached for use as the	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. tf yes, outcome of pregnancy		le in				23d. Da	te of delive	ery
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that the de led by the a	hys	9 Unknown								4.1.110
res tha igned	by	Part II. Other significant conditions contributing to death but not resulting in	the ur	iderlying cause give	n in Part I.		23e. Dia toba			ne cause of death?
w requir been si	eted					_				
e law has t	Completed					_	24a. Was an autopsy perform	ed?	Were auto prior to cor death?	psy findings available mpletion of cause of
							1□ Yes 2	No	1 🗆 Yes	2 No
vital necessician: The law	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No  Hospital: 1 ☐ Inpatient 2 ☐ ER/Ou	tnation	Othor			Check only one, 5 ☐ Residen		or (Specifi	u)
g Phys er this eral di		27. Manner of Death 28a. Date of Injury 28b. T	ime of	28c. Injury Work			d. Describe how			<i>'</i>
ath. r: After te funerie	atio	2 Accident investigation	njury		es 2 N	0				
or Attend after death Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, fa building, etc. (Specify)	rm, stre	eet, factory, office		28f	. Location (Stre City or Town,		er or Rura	l Route Number,
urs aft		M O with Similar	4		- 4-1		4 4			
To the Hospitel or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely illied in by the funeral director.	edical	29a. Certifier (Check only one)  1. Certifying Physician: To the best of my knowledge (Check only one)  2								
To the within To the	Me	29b. Signature and title of certifier		29c. License	number		290	d. Date signe	d (Month,	Day, Year)
7		Muner Durs		Do	0511	58	N	OVENB	KN S	2005
1		30. Name and address of person who completed cause of death (Item 23a) (	Type, I	Print)				W A 3	000	^
		VATTIT. ANTHONY 9701 VEINS	DI	2106 1	LOCK	VILL	-E ,	TID L	0860	
Sta Regist	ate rar	VATTI J. ANTHOMY 9701 VE(NS 31. Date filed (Month, Day, Year) NOV 0 8 2005 32 Registrar's Signature	Hol	rte						

			For State Registrar	State of	Marylan		artmeni rtificate				lental Hy	gien	21115	3	7898
1			Decedent's Name (First, Middle	, Last)							2. Date of De	aath		3.	Time of Death
8	Physici /Medic	cal	ENTERAN 4a. Facility Name (If not institution,			TABI		Tours or	Location o		CO BE	ER	ay Yea	05 10	0.44 A M
	Examir	ner	Shady Grove A	•	-	1		ckvi		or Death		41	c. County of De Montgo:		
	Funeral			6. Sex 7.	Age (In yrs. I		If Under	1 Year	If Under:		8. Date of Bi	rth .			(State or Foreign
Sept.	Director		216-27-5284	1 M 2 F	74	Yrs.	Months	Days	Hours	Min.	Dec. 1	4 <b>,</b> rear	1930	Tra	(State or Foreign 3.11
	and		Usuel Residence of Decedent  10a. State 10b. County		10c. City	y, Town or Lo	cation							10d Ir	nside City Limits
	Maryl f sho	ō	Maryland Montg	omery		ithers									Yes 2 No
	r 28a	irec	10e. Street and Number				10f. Zip	Code				10g. C	itizen of What (	Country?	7
	th wit	ai D	252 Gold Kettle	Drive			2	0878				U	. S. A.		
	r dea	ne	11. Marital Status	12. Was Decede Armed Force	es?	S. 13.	Was Deced	ent of His	spanic Orig	gin? (Spe	ecify Yes or No Rican, etc.)	D-	14. Race - An Black, Wh		dian,
36	within 72 hours after death with the Maryland ene. then "neture!", or items 23e or 28e-f show I.a Madical Exertirer must be notified at	by Funeral Director	1 ☐ Never Married 2X Marri 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	_		1 ☐ Yes 2		Specify:		, , , ,			White	е
21215-0036	2 hour	edb	15. Decedent	Year or Date s Education	)S: 	16a. Dece	dent's Usua	l Occupa	tion			16h	Kind of Busines	s/Industra	,
215	hin 72 nn "na Madik	Completed	(Specify only highes Elementary/Secondary (0-12)	grade completed) College (1-4	or 5+)	(Give	kind of wor DO NOT us	k done du	urina most	t of worki	ng	100.1	rand of busines	armoustry	,
21	giene gerth	Com	12 Years	College (1-4	01 34)	Hom	emake	r				(	Own Hom	e	
nd	be file ital Hy d oth event	Be	17. Father's Name (First, Middle, I								(First, Middle				
<u>Ş</u>	d Men narke	ဥ	Houshang Sou			101 11 11		10. 5			narkhta				
Baltimore, Maryland	nd 2 silith and 2 to 15 r is r traur		Sina Soumekhian								le, Mar		or Town, State, nd 208.		9)
re,	of Head item		20a. Method of Disposition		^-	Lace of Dispo emetery, crer	sition (Nam	e of	, 1	D	ate	20c. L	ocation - City o	r Town, S	State
Ĕ	Page ment		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sc							10/2	7/2005	C1	arksbur	g, M	aryland
Balt	perriit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Importants if item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, II a Madical Examination must be notified at once.		21. Signature of Funeral Service	icensee	Yemese			_					on, Inc. e, Mary		20852
	-37		23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that cau	sed the death	. Do not ent	er the mode	of dying	, such as	cardiac o	r respiratory a	rrest,	e, mary	Appi	roximate
	Physician		Immediate Cause (Final disease or condition	CFR	E BRO	OVAC	(0)	AR	Ac	e-11	ENT				val Between et and Death
	/Medical Examiner		resulting in death)	Due to (or	as a consequ	uence of):		, , , ,		7 0	ENT			C	ONIS
	LAdriller	<b>b</b>	Sequentially list conditions,		IAL as a consequ		RILL	ATTO	N_					and.	18985
	ned Insit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due 10 (6)	as a consequ	ierice or):									
Ć.	be executed sicten and burial-transit	Еха	that initiated events resulting in death) Last	c	as a consequ	ience of):									
8760,	icate be executed physicien and s the burial-transit	dicai		d											
9	artifica ing ph e as th	Med	IF FEMALE:												
Вох	eath certific attending p for use as	lan/	23b. Was decedent pregnant in the past 12 months?		2 Fetal	death 3	Ectopic pre						23d. Date of de	elivery Day	'Year
o.	The law requires that the death certific tie has been signed by the attending p bage 2 should be detached for use as	Physician/Me	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4⊟Pregnan 9⊡ Unknow	t at time of de	eath 5	Other (spe	ecify)					(1101)	Duy	7 047
0	that ned by deta	by Ph	Part If. Other significant condition	s contributing to death	h but not resu	ılting in the ur	derlying ca	use giver	n in Part I.		23e. Did t	obacco	use contribute	to the cau	ise of death?
Records,	w requires been sign should be										101	Yes 2	2.□No 3□F	robably	4 Unknown
ဝ၁	law requas been 2 should	Completed									24a. Was		24b. Were a	utopsy fir	ndings available
		Com					-				autor perfo	rmed2 2 No	death?		on of cause of
Vita	ilcian: Th certificate rector, pag	Be (	25. Was case referred to medical examiner?					- 7			Check only o	ne			
<del> </del>	this al di	7	1 Yes 2 No	Hospital: 1 Inpa		ER/Outpatien		Other	4 🗆 Nur				6 Other (Spe	ecify)	
Division of	ing Mfter une	tion	27. Manner of Death  Natural 5 Pending  Accident Investig		Day Year)	28b, Time of Injury	м 28	3c. Injury a Work?	at es 2⊡N		8d. Describe l	now inju	iry occurred		
/ISI		flca	3 Suicide 6 Could n	ot be 28e. Place of	Injury - At hor	me, farm, stre					8f. Location (5	Street ar	nd Number or F	ural Rou	te Number
	urs afte	Certification:	4 D HOITIGUE	building,	etc. (Specify						City or Tov	vn, State	e)		
	To the Hospital or A within 24 hours after To the Funeral Directorphisms ompletely filled in by	Medical	29a. Certifier 12 Certifying (Check only one) 2 Madical E	Physician: To the be xaminer: On the basis and manner	s or examinati	vledge, death ion and/or inv	occurred a estigation, i	it the time in my opii	e, date and nion, death	d place, a h occurre	nd due to the	cause(s date and	s) and manner a d place, and du	s stated. e to the c	ause(s)
	To t To t	Σ	29b. Signature and title of certifier				29c.	License	number			29d. Da	ate signed (Mon	th, Day, Y	(ear)
	V		MUNI	DIT P. I	CURUV	ruca,	NO	14	.618	7	(	DLIC	BER 8	27,	2005
	-		30. Name and address of person w	ho completed cause of	f death (Item	23a) (Type, I	Print)	2	4/ -	200	Carre				C 0
2	Sta	te	31. Date filed (Month, Day, Year)	32. Regi	strar's Signati	ure (	LE F	IKE	, At-	108	MOCKI	nuc	LUD	20	67
	Registr		NOV 0 8	the completed cause of the completed cause of the completed cause of the complete cause of the cause of the complete cause of the complete cause of the complete cause of th	eyes d	K A	gues!						3.50		

			1 - For AMEND#5per INF11/10 State Ragistrar AMEND#29dperMD	11/8/05,EM	larylan I,MbCo	id / Depa <i>Cei</i>	artmen rtificat	t of H e of L	ealth a Death	and M	ental Hy	giene Reg. Ne.	003	5	378	99
***	Physici /Medi		Decedent's Name (First, Middle, Last, Harold Leslie	Carlson							2. Date of De Month Novem	Day	4, 20	rear 005	3. Time	of Death
	Examir		4a. Facility Name (If not institution, give Manor Care-Bethe		r)			Town, or	Location o	of Death		4c.	County of		v	
	Funeral Director		5. Social Security Number 6. Sec. 198-16-0854 15	7. A	ige (In yrs. 83	last birthday) Yrs.	If Under Months	1 Year Days	If Under : Hours	24 Hrs. Min.	8. Date of Bir (Month, Da July 3	rth ay, Year)		9. Birthpl Coun	ace (State	or Foreign
	Maryland	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Montgom	lerv		y, Town or Lo									Od. Inside (	
	h with the	ai Director	10e. Street and Number 807 Houston Avenue			axoma	10f. Zip		912			10g. Citiz	zen of Wh	usat Coun	try?	
036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.	by Funeral	11. Marital Status  1 Never Married 2XMarried  3 Widowed 4 Divorced	12. Was Deceden Armed Forces 1 X Yes 2 If Yes, Give Year or Dates	? ] No		Was Deced f Yes, spec	ofy Cubar	spanic Orig n, Mexican Specify:	gin? (Spe , Puerto I	cify Yes or No Rican, etc.)		A. Race - Black, Specify: V	White, e	etc.	
21215-0036	d within 72 ho piene. r than "natu	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e <i>completed)</i> College (1-4or 2	5+)	16a. Deced (Give life. L Carpe	kind of wor DO NOT us	rk done d se retired)	luring most }				nd of Busin		ustry armin	a
Maryland 2	und be filed Mental Hyg Irked othe	To Be C	17. Father's Name (First, Middle, Last) Ephrim A. Carlson						18. Mothe	r's Name	(First, Middle, tquist	. Maiden .				5
, Mar	and 2 sho ealth and I m 27 Is m		19a. Informant's Name/Relationship (Ty Alice J. Carlson/			807	Hous	ston			Route Number					
Baltimore,	tment of H tant: If Ite		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ R  4 ☐ Donation 3 ☐ Other (Specify)	1 1		Place of Dispo- emetery, crem sel Vall	natory or or	ther place		N	lov. 8 2005		dlers	•		PA
Bal	Departition Depart		21. Signatur of Fureral Service Licen	y cer	elo	50	0 Uni	vers	ity E	31vd,	uneral W, Si	lver	e Inc Spri	ing,	MD 20	901
	Physician /Medical Examiner	er	23a. Part 1. Enter the disease or complishock, or heart failure. List only of Immediate Cause (Finat disease or condition resulting in death)  Sequentially list conditions.  Lary loading to immediate cause. Enter Underlying	Leukem  Due to (or a	ine. ia saconsequ te Ca	uence of): .ncer	er the modi	e or aying	g, such as o	cardiac or	respiratory a	rrest,			Approxima Interval Be Onset and	tween
8760,	icate be executed physicien and the burial-transit	dicai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	s a consequ	uence of):										
Box 6	death certiff e attending id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1□Live birth 4□Pregnant a 9□Unknown	2 Fetal	death 3	Ectopic pre Other (spe					23	3d. Date o Month	•		Year
ords, P	The law requires that the sie has been signed by thoage 2 should be detached.	ρχ	Part II. Other significant conditions con	tnbuting to death	but not resu	ulting in the un	derlying ca	ause givei	n in Part I.		23e. Did to	obacco us			cause of	
al Record		Completed									24a. Was autop perfor 1 Yes	rmed?	dea	re autops r to com th? Yes 2	sy findings pletion of (	available cause of
₹	Physician: this certifice ral director, I	Be	25. Was case referred to medical examiner?	ospital:				Othor			Check only o					
Division of Vital	After fune	tion: To	1  Yes	1 ☐ Inpati 28a. Date of Inj (Month, Da	ury	ER/Outpatient 28b. Time of Injury		Bc. Injury	4 ZFNur	28	e 5 🗌 Resid 8d. Describe h			(Specify)		
Divis	Dig afte	Certification:	3 Surcide 6 Could not be determined	28e. Place of Inbuilding, e	jury - At ho tc. (Specify	me, farm, stre					Bf. Location (S City or Tow	Street and vn, State)	Number	or Rural i	Route Nun	nber,
	Hospital or 24 hours afte Funeral Dire stely filled in I	edical	29a. Certifier  (Check only one)  1X Certifying Physical Exercise (Check only one)	ician: To the best	of my know	wledge, death	occurred a	it the time	e, date and	l place, ar	nd due to the o	cause(s) a	ind manne	er as stat	ted.	-1
	To the I within 2 To the I complet	Med	one)  29b. Signature and title of certifier	and manner	ated.	1		License				29d. Date				.,
)	7+1	1	30. Name and address of person who co	mpleted cause of	death (have	20th Tuna 5			C51	750		11/	1-4-2	005	5	_
0	( ) 1		Anushiravan Dadg	ar-Dehko	rdi,	M.D. 1	3219	Exec	utive	Par	k Terr	ace,	Germ	anto	wn,	MD
	Sta Registr		31. Date filed (Month, Day, Year)	7	rar's Signat	mile	ALL F									

STT	e Davis	1	For State	State of Maryland	d / Depa <i>Cel</i>	artment of F rtificate of	lealth and N Death			37900
rive .	€ #		Registrar  1. Decedent's Name (First, Middle, Las	st)		tinoate or	Douin	2. Date of Dea		3. Time of Death
	Physicia	ın	Lavelle	Davis				October	Day Year 30, 2005	04:25 A M
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Death		4c. County of Dea	
	Funeral Director		Prince George's H 5. Social Security Number 6. S 327-66-0837		ast birthday) Yrs.	Chever1y If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day)	, Year) Co	thplace (State or Foreign ountry)
	pc ,		Usual Residence of Decedent	10a City	, Town or Lo	antina				10d. Inside City Limits
	Maryla e-f ehov	ctor	10a. State 10b. County Fairfax		andri					1 ☐ Yes 2€No
	death with the Maryland rms 23a or 28e-f ehow r must be notilled at	ai Dire	10e. Street and Number 8684 Village Squa	are		10f. Zip Code 22309	)	1	U. S.	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28e-f show other traumatic event, the Medical Examiner must be notified at	Completed by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☐ No	dispanic Origin? (Si an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit	te, etc.
5-0	72 hc	eted	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	16a. Dece (Give	dent's Usual Occup kind of work done DO NOT use retired	ation during most of wor	king	16b. Kind of Business	/Industry
21	e filed within at Hygiene. I other then "vent, the Mar	du	Elementary/Secondary (0-12)	College (1-4or 5+)			d)		Mana	
	Hygie Hygie Ither t	ပိ	17. Father's Name (First, Middle, Last)	<u> </u>	OH	employed	18. Mother's Nan	ne (First, Middle,	None Maiden Surname)	
ano	d be i	o Be	Robert Fry				Patricia			
Maryland	shouls nd Me mark mati	၉	19a. Informant's Name/Relationship (	Type, Print)	19b. Maili	ng Address (Street	and Number or Ru	ral Route Number	r, City or Town, State,	Zip Code)
	nd 2 alth a latter tract		Crystal Davis - v	wife	8684	Village	Square, i	Alexandr:	ia, VA 2230	09
Baltimore,	permit. Pages 1 an Department of Heal Important: if item 2 eny injury or other once.		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif	Removal from State	emetery, cre	osition (Name of matory or other place			20c. Location - City or	
3altir	permit. P Departme Importan eny injur:		21. Signature of Funeral Service Lice	100	1 2	Cemetery 2. Name and A. dre	ee of Facility	ll−05   ∟ Lewis Fu	Alexandria neral Home dria, VA 22	
	20.5 • a	-	of the Familia diameter							2314 Approximate
	Physician /Medical		23a. Part 1. Enter the disease, or con hock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a Gunshot u	noun	d of c		, or respiratory an	651,	Interval Between Onset and Death
100	Examiner			Due to (or as a consequ	ience ot):					
2.4	pd iii	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	b. Due to (or as a consequ	uence of):					
Ć,	execute on and ial-trans	Examiner	that inifiated events resulting in death) Last	cDue to (or as a consequ	uence of):					
68760,	icate be executed physicien and s the burial-transit	edicai		d						
P.O. Box 6	law requires that the death certifi es been signed by the attending 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3	⊒Ectopic pregnanc ⊒ Other (s <i>pecify)</i>	у		23d. Date of de Month	olivery Day Year
	juires that n signed t	þ	Part II. Other significant conditions of	contributing to death but not resu	ulting in the u	underlying cause giv	ven in Part I.		bacco use contribute t es 2 🛱 No 3 🗆 P	o the cause of death?
Division of Vital Records,	The law requirete law requirete hes been sipage 2 should	Completed						24a. Was a autopo perior	sy prior to med? death?	utopsy findings available completion of cause of
ita	ician: certifice rector, p	Be C	25. Was case referred to medical				26. Place of Dea	ath (Check only or		
<u>&gt;</u>	hysici nis ce I direc	ToE	examiner?	Hospital: 1 ☐ Inpatient 2 ☑	ER/Outpatie	nt 3LI DOA		lome 5 ☐ Resid	ence 6 Other (Spe	ecify)
0	Attending Physician: r death. ector: After this certification the funeral director.		27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wo	ry at rk?	. 1	ow injury occurred	+
Sio	death death stor: /	cati	2 Accident investigation 3 Suicide 6 Could not be		3>30 1	1	Yes 2 No	Subject	treet and Number or R	
Divi	s after of Direct of Direc	Certification;	4 N Homicide determined	28e. Place of Injury - At ho building, etc. (Specify		CAY		City or Tow	n. State) 8700 p	ennsylvania mi
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fo	Medical	29a. Certifier 1 Certifying Plant (Check only one)	nysician: To the best of my know miner: On the basis of examinat and manner stated.	wiedge, deat tion and/or in	th occurred at the ti	me, date and place opinion, death occu	a, and due to the d urred at the time, o	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
	Within To th comp	Me	29b. Signature and title of certifier			29c. Licens	se number	ż	29d. Date signed (Mon	th, Day, Year)
			I him his,	mid		0.C.1	M.E.	0	ctober 31,	2005
R	-2		30. Name and address of person who	completed cause of death (Item			eet, Balt		aryland 21	
	Sta Regist		31. Date filed (Month, Day, Year) NOV 0 9 2005	32. Registrar's Signa	ture					

			1- For State of Maryland / Dep Registrar Ce	artment of Health and M		211115	37901
	Direction.		Hegistrar  1. Decedent's Name (First, Middle, Last)	Timeate of Death	2. Date of Death		3. Time of Death
	Physici /Medic	al	ROBERT RAY DENNY		NOVEMBER	<sup>2</sup> 5, 2005	4:35 P M
	Examin	er	4a. Facility Name (If not institution, give street and number) 8411 OAK DRIVE	4b. City, Town, or Location of Death BRANDYWINE		4c. County of Deat PRINCE GE	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,		8. Date of Birth	0.0:-	thplace (State or Foreign
	Director		415-30-5230		OCT 16,	1924 TEN	NESSEE
	ryland thow		10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
	he Ma 28a-1	ecto	MARYLAND PRINCE GEORGE'S BI	RANDYWINE			1 ☐ Yes 2 💢 No
	3a or 3	Funeral Director	8411 OAK DRIVE	10f. Zip Code 20613		g. Citizen of What Co JNITED STA	,
	r deeth	ınera	11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces?	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto		14. Race - Ame Black, Whit	erican Indian,
36	within 72 hours after deeth with the Maryland lene. r then "natural", or Itema 23a or 28a-f ehow the Medical Exartirat roust be notiliad at	by Fu	1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Never Married 2 Never Married 1 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 3 Never Married 2 Never Married 3 Never Married 2 Never Married 3 Never Married 2 Never Married 3 Never Ma	1 ☐ Yes 2 No Specify:	, , , , , , , , , , , , , , , , , , , ,	Specify:	WHITE
21215-0036	72 hou		15. Decedent's Education 16a. Dece	edent's Usual Occupation se kind of work done during most of work	ine 10	6b. Kind of Business	
121	within lene.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	ERAL MANAGER		говассо со	MDANV
d 2	Hyg the	Be Co	17. Father's Name (First, Middle, Last)		e (First, Middle, Ma		MEANT
ylan		To B	GEORGE HAROLD DENNY	EMMA L	YON WHITA	AKER	
Maryland	2 sh and le m			OAV DDTVE DDANDV			Zip Code)
	s 1 and f Health item 27 other ti		20a. Method of Disposition 20b. Place of Disp	OAK DRIVE, BRANDY osition (Name of imatory or other place) NOVE	-	0c. Location - City or	Town, State
Baltimore,	Pages nent of ant: if it ury or o		1 ☐ Burial 2 ★ Cremation 3 ☐ Removal from State  1 ☐ Donation 5 ☐ Other (Specify)			ALDORF, MA	ARYLAND
Balt	permit. Page Department o Important: if any Injury or once.		111 0 00 0	2. Name and Address of Facility  JNTT FUNERAL HOME,	P.O.BOX	156, WALE	20604 DORF, MD
	.e		23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.		· · · · · · · · · · · · · · · · · · ·		Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	arrest			Onset and Death
	Examiner		Due to (or as a cogsequence of):	Maclon	a		5
	p #	Iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	0			1
	xecute and	Examiner	Cause (Disease or injury that initiated events resulting in death) Last    C. Due to (or as a consequence of):				
8760,	icate be executed physicien and s the burial-transit		d.				
9	h certifical anding phy use as th	Medi	IF FEMALE:			1	
Вох	atte for	Physician/Medical	23b. Was decedent pregnant in the past 12 months?	□Ectopic pregnancy □ Other (specify)		23d. Date of de Month	elivery Day Year
0.	at the de by the a tached	hysic	1   Yes 2   No 9   Unknown				
S, P	es the	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	/	_	to the cause of death?
oro	v requir been s should	eted	name of marine	- organ			robably 4 Onknown
Vital Records,	The ate h	Completed	- reconsper my		24a. Was an autopsy perform	prior to	
Vita	Physician: Th this certificate rel director, pag	Be	25. Was case referred to medical examiner?	Othor	h (Check only one	)	
of		n: To	27. Manner of Death 28a. Date of Injury 28b. Time		ome 5 esider 28d. Describe hov	nce 6 □Other (Spe w injury occurred	ecify)
ion	Attending in death.	atio	1 Natural 5 Pending (Month, Ďay Year) Injury 2 Accident investigation	Work? M 1 ☐ Yes 2 ☐ No			
Division		Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Stre City or Town,	eet and Number or R State)	Rural Route Number,
	To the Hospital or At within 24 hours efter c To the Funeral Direct completely filled in by	edicai	29a. Certifier (Check only one)  1				
)	To the within 2 To the Complet	Ž	29b. Signature and title of certifier	29c. License number	9	d. Date signed (Mon	
0	1361631		30. Name and address of person who completed cause of death (Item 23a) (Type RENE E. GRACE, MD, 9131 PISCATAWAY RI	)., #260, CLINTON,			
Ì	Sta Registr		31. Date filed (Month, Day, Year) 32. Signature NOV 0 7 2005	porte			
-		104					<del></del>

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) November 8, 2005 **Physician** Mildred Lee Drinkard /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Charles County Nursing & Rehab LaPlata Charles Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 M 2 K 216-38-5160 90 15,1915 Virginia Director Aug. Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if Itsm 27 is marked other than "natural", or itsms 23a or 28e-1 show any highry or other traumatic event, the Madical Expanhermant be natified at once. 1X Yes 2 □ No Maryland Charles Indian Head Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1036 East Potomac Ave. 20640 U.S.A. Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White þ 3 ₩Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Her Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be William Brown Effie Scrimger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Lloyd Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Nov. 11, 2005 10734 Lloyd Point Rd., Newburg, Md. 20664 20c. Location - City or Town, State 20a. Method of Disposition ty Buriaf 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Wayside, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Williams Funeral Home, P. A. 20640 Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or rear failure. List only one cause on each line. M00668 Indian Head Approximate interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a coperquence of) Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medicai use as the IF FEMALE: ff yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Dav 5 Other (specify) 4☐Pregnant at time of death Division of Vital Records, P.O. 9 Unknown 9 Dunknown Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ sate has been signi page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 🗆 No certificate 219NO 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification; To After the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Naturat Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident To the Funeral Director: completely filled in by the f 6 Could not be determined 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospitel o within 24 hours at To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

135

State Registrar HENRY L. BURKE, M.D. 1/3
31. Date filed (Month, Day, Year)

32. Registrar's Signature

NOV 0 9 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D. 115A LA Grange Ave, La Plata, Md. 20646 Registrar's Signature

00001009

			1 - For State Registrer	State of	of Marylai	nd / Depa <i>Cei</i>	artment of hartificate of	lealth and Death		giené Reg. No.		37903
			Decedent's Name (First, Middle,	Last)					2. Date of De	ath		3. Time of Death
	Physicia		Blanche Dombrows						Novemb	er 8	2005	9:15 P <sup>M</sup>
	/Medic		4a. Facility Name (If not institution,		ımber)		4b. City, Town, o	or Location of Dea			County of De	
	Examin		Homestead Manor			7	Denton				Carol:	ine
				6. Sex		. last birthday)	If Under 1 Year			th		rthplace (State or Foreign country)
	Funeral Director		132-40-5781	1 ☐ M 2 🔯 F	86	Yrs.	Months Days	Hours Min	Nov. 2	1 <i>y</i> , rea <i>r</i> )	19 Net	V York
			Usual Residence of Decedent						11.011	,		, JOIN
	/land		10a. State 10b. County		10c. C	ity, Town or Lo	cation					10d. Inside City Limits
	Mar.	to	Maryland Caroli	ne	De	enton						1 ☐ Yes 21XXNo
	r 28a	Director	10e. Street and Number				10f. Zip Code			10g. Citi	zen of What C	Country?
	3a o	O E	401 Colonial Dri	ve			21	629		Un	ited St	tates
	ms 2	Funeral	11. Marital Status		edent Ever in t	J.S. 13.	Was Decedent of I	Hispanic Origin? (	Specify Yes or No		14. Race - Am Black, Wh	erican Indian,
36	be filed within 72 hours after death with the Maryland the Hygiene. do chhar than "natural", or itams 23a or 28a-f show to chhar than "natural", or itams 23a or 28a-f show swant, the Medical Exspirier must be notified at	by Fur	1 ☐ Never Married 2 ☐ Marrie 3 Widowed 4 ☐ Divorced		2 ፟⊠ No ive		1 □ Yes 2 ☑ No		no moan, etc.)			White
Maryland 21215-0036	hou	ed	15. Decedent'			16a. Dece	dent's Usual Occup	pation		16b. Ki	nd of Busines	s/Industry
<u>.</u>	in 72	Completed	(Specify only highest	grade completed,		(Give	kind of work done DO NOT use retire	during most of wo	orking			
12	with ene. thar	E C	Elementary/Secondary (0-12)	College	1-40r 5+)	Н	omemaker			10	wn Home	2
9	filed Hygin Sthar		17. Father's Name (First, Middle, L	ast)	-			18. Mother's Na	ame (First, Middle			
a	Mental Mental arkad c	To Be	Joachim Gabrus					Teofi	lia Trub	ish		
<u></u>	s 1 and 2 should be of Health and Menta itam 27 Is marked other traumatic so	۲	19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Mailir	ng Address (Street	and Number or F	Rural Route Numb	er, City o	r Town, State,	Zip Code)
Š	od 2 in ar		Diane Reichlin /	Daughte	r	1397	Hunting 1	Horn Lan	e. Frede	rick	MD 21	702
စ်	Health Health tam 27 other tra		20a. Method of Disposition	Daugnee		Place of Dispo	sition (Name of matory or other pla		Date	20c. Lo	cation - City o	
2	ages ont of t; If i		1 ☐ Burial 2 ☑ Cremation 1 ☐ Donation 5 ☐ Other (Sp			•		11000	ember 10, 2005			Vanual and 1
altimore,	artme artme ortan injuri		21. Signature		Gr		t Cremat Name and Addre	The second secon				Maryland
Ba	permit, Pages 1 Department of H Important; If ita any injury or ot once,		0119			95	2. Name and Address thaven 01 Catoo	tin Mtn.	Hwy. Fr	eder	kot Co ick, M	D 21701
			23a. Part1. Enter the disease, of shock, or heart failure.	complications that only one cause on	caused the dea each line.	th. Do not ent	er the mode of dyi	ng, such as cardia	ac or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	DNG.	eumo	mia						Criser and Boath
	/Medical		resulting in death)	Due to	(or as a conse	quence of):		· · · · · · · · · · · · · · · · · · ·				
	Examiner		Sequentially list conditions	b								
	n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury	Due to	(or as a conse	quence of):						
	cuter	Examin	that initiated events	с.								
o Ô	icate be executed physician and s the burial-transit	Ä	resulting in death) Last	Due to	(or as a conse	quence of):						
8760,	ate bi nysic he bi	dlcal		d								
	ng ph ng ph as t	00 1	IF FEMALE:									
Вох	The law requires that the death certifi tie has been signed by the attending i cage 2 should be detached for use as	Physiclan/M	23b. Was decedent pregnant		itcome of pregr birth 2 □Fet		Bectopic pregnanc	:y		2	23d. Date of de Month	olivery Day Year
П	s dea he att ed fo	sici	in the past 12 months?	4□Preg 9□Unkr	nant at time of	death 5	Other (specify) _					
о. О	res that the de signed by the a be detached t	h	9 Unknown						an Did		no contributo	to the cause of death?
Č.	gned go de	by	Part II. Other significant condition	ns contributing to	death but not re	sulting in the u	nderlying cause gi	ven in Part I.				
5	w require been si should t								1	Yes 2	DINO 3 L	Probably 4 Unknown
ပ္က	taw re as be 2 sho	Completed							24a. Was	DSV	24b. Were a	autopsy findings available completion of cause of
Vital Records,	: The ta cate has page 2	E							perfo 1 ☐ Yes	ormed?	death?	
		0	25. Was case referred to medical					26. Place of De	eath (Check only	one)		2
	Physician: r this certifici ral director,	0 8	examiner? 1 □ Yes 2 <b>2</b> No	Hospital: 1 □	Inpatient 2	☐ ER/Outpatier	nt 3□ DOA Ot	her: 4 🗆 Nursing	Home 5 ☐ Resi	dence 6	S K Other (Sp.	ecify)
0	ding Ph h, After thi funeral	n:T	27. Manner of Death	28a. Date	of Injury oth, Day Year)	28b. Time o			28d. Describe		y occurred	
<u>0</u>	Attanding ir death, actor: After by the fune	atio	1 Matural 5 ☐ Pending 2 ☐ Accident investig		in, buy rour,	,,		Yes 2 □ No				
Division of	Atta arcto by th	iii	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 289. Plac	e of Injury - At I	nome, farm, sti	eet, factory, office		28f. Location ( City or To	Street an	d Number or F	Rural Route Number,
	s afte	Certification:	4 C Homeldo	Dank	arig, otc. (Dpoc						′ 	
	To tha Hospital or Attandi within 24 hours after death. To the Funaral Diractor: A completely filled in by the fu	edical (	29a. Certifier 1 Certifying (Check only one)	Physician: To the xaminer: On the	e best of my kr basis of examin	owledge, deat ation and/or in	h occurred at the ti vestigation, in my	ime, date and plac opinion, death occ	ce, and due to the curred at the time,	cause(s) date and	and manner a place, and du	is stated. e to the cause(s)
	o tha ithin o the omple	Med	29b. Signature and title of certifier				29c. Licen	se number		29d. Dat	e signed (Mor	oth, Day, Year)
	F ≶ F Ö					(ND)	Dog	53325	5	111	1910	5
	j		30. Name and address of person v	vho completed car	ise of death (Its	m 23a) (Type	Print)				, ,	
	1			•			and the same of th	resto	om ~	a	1455	>
	Sta	te	Melinda But 31. Date filed (MoNO), Pa	2005 32	legistrar's Sigr	nature	Company of the Compan					
	Registr		,,,,,,	2003	year.	N A						

		1 - For State Registrar	State of Maryland	d / Depa <i>Cei</i>	artment of H tificate of	lealth and <i>Death</i>		giene () (	37904
Physical		1. Decedent's Name (First, Middle, Las					2. Date of De Month		3. Time of Death
Physicia /Medic		ROGER	W	D	ORSEY		Noveml		
Examine	er	4a. Facility Name (If not institution, give			4b. City, Town, o	or Location of Dea	ith	4c. County of Howal	on death
		8742 Mission F		ast birthday)	If Under 1 Year	If Under 24 Hr		th g	. Birthplace (State or Foreign
Funeral Director			DM 2□F 89	Yrs.	Months Days	Hours Mir	Dec. 2	2,1915 I	Maryland
ס	1	Usual Residence of Decedent	10- Cit.	T					10d. Inside City Limits
arylar ehow	_	10a. State 10b. County	Toc. City	, Town or Lo					1⊠Yes 2 No
Be-f	Director	MD Howard  10e. Street and Number		<u> </u>	essup			10g. Citizen of Wh	
with t	٥	8742 Mission	Road			794		U.S	
death	Funeral	11, Marital Status	12. Was Decedent Ever in U.S	S. 13.	Was Decedent of H	lispanic Origin? (	Specify Yes or No rto Rican, etc.)	- 14. Race -	American Indian,
or Iter		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give	1	t Yes, specify Cub 1 □ Yes 🏖 No		πο Hican, etc.)		white, etc. Black
72 hours after death with the Maryland nature!; or Items 23a or 28a-f ehow alcal Examiner must be notified at	d by	3 XWidowed 4 ☐ Divorced	Year or Dates:						
natu	Completed	15. Decedent's Ed (Specify only highest gra		16a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retire	oation during most of wi d)	orking	16b. Kind of Busin	County
withir ene. then	duc	Elementary/Secondary (0-12) 7th	College (1-4or 5+)		odian	-/			Schools
Hygi other ent,	Be C	17. Father's Name (First, Middle, Last)						Maiden Sumame)	
should be filed within and Mental Hygiene. In marked other then "	To B	Walter Do:	rsey			Mary	Johnso		
2 sho and h		19a. Informant's Name/Relationship (						er, City or Town, St.	
and and m 27 her tr		Bessie Bordena	ve-Daugneer	1	sition (Name of	II KOau	Date	20c. Location - Ci	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. The Important: If them 271e marked other then "natural; or Items 23a or 28e-f ehow any injury or other traumatic event, it whe lical Examinet must be notified at any injury or other traumatic event.		20a. Method of Disposition 1   ■ Burial 2 □ Cremation 3 □	Removal from State	metery, crer	natory or other pla Mem Pa	erk   11	/7/2005		
it. Pa		'4 □ Donation 5 □ Other (Specification of Funeral Service Licen						COTUM	Home, P.A.
permit. Departi		21. Signature pri Pulletar Service Elder	F Vans	01	246 N. V	Washing	ton St	Rockvil	le,MD20850
		23a. Part1. Enter the disease, or com	plications that caused the death						Approximate Interval Between
Physician		shock, or heart failure List only Immediate Cause (Final disease or condition	PARKINSC	NI S	DISEASI	Ε			Onset and Death 5 years
/Medical		resulting in death)	Due to (or as a consequ						
Examiner		Sequentially list conditions,	b						
ped isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	ience or):					
be executed ician and burial-transit	xan	that initiated events resulting in death) Last	c Due to (or as a consequ	ience of):					
bur gia	dical		d						
To the Hospitel or Attending Physician: The law requires that the death certificate within 24 hours after death.  Within 24 hours after death.  Sompletely filled in by the funeral director, page 2 should be detached for use as the									
th cer tendir r use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnat	ncy death 3[	Ectopic pregnanc	у		23d. Date of	
e dea the at	sic	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at time of de 9☐ Unknown	eath 5	Other (specify) _			, work	Juy / Jul
w requires that the death certific been signed by the attending p should be detached for use as it		Part II. Other significant conditions of	ontributing to death but not resu	ulting in the u	nderlying cause giv	ven in Part I.	23e. Did t	obacco use contrib	ute to the cause of death?
signe d be d	d by	Blepharospası			, ,		10	Yes 2 <b>X</b> No 3	☐ Probably 4 ☐Unknown
v requ	Completed						24a. Was	an 24b. We	re autopsy findings available
he lay	ошо		· · · · · · · · · · · · · · · · · · ·					ormed? dea	or to completion of cause of alth?  Yes XIXNo
an: T an: T lifficate or, pa	CO	25. Was case referred to medical				26. Place of De	1 ☐ Yes eath (Check only o		165 42440
ysicii is cer direct	To B	examiner? 1 □ Yes 2∰ No	Hospital: 1 Inpatient 2 I	ER/Outpatier	t 3 DOA Ott	ner: 4 🗆 Nursing	Home 5X Resi	dence 6 Other	(Specify)
neral		27. Manner of Death 1  Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wo		28d. Describe	how injury occurred	
tendii leath. tor: A	cati	2 Accident investigation 3 Suicide 6 Could not be	9		1	Yes 2 □ No	204 Lacation /	Street and Number	or Rural Route Number,
or At or At or At or At or At or At or At	Certification:	4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, tarm, sti	eet, factory, office		City or To		or uniter notite redifficer.
To the Hospitel or Attending Physician: The law within 24 hours after dash.  To the Funeral Director: After this certificate has bompletely filled in by the funeral director, page 2		29a. Certifier XIX Certifying Ph	ysician: To the best of my know	wledge, deat	n occurred at the ti	me, date and place	e, and due to the	cause(s) and mann	er as stated.
e Hos 124 h e Fur letely	edical	(Check only 2 Medical Exer	niner: On the basis of examinat and manner stated.	tion and/or in	vestigation, in my	opinion, death occ	curred at the time,	date and place, and	I due to the cause(s)
To the Hospitel or Attending R within 24 hours after death. To the Funeral Director: After Completely filled in by the funer	Me	29b. Signature and title of certifier	11 11 11		29c. Licens			29d. Date signed (	
5		I ten l	elle Mill		D3	34613		Novembe	r 3, 2005
		30. Name and address of person who	completed cause of death (Item	23а) (Туре,	Print)	To I leave 4 -	ao MD	21075	
		Steven Geller 31. Date filed (Month, Day, Year)	, MD 8186 La	rk Br	own Kd	FIKLIO	ge, MD	21013	
Sta Registra			32 Registrar's Signal	Apple	ules.				

			1 - For Stete Amend It	State of Macen 1,23a pe	aryland er Dr.	/ Depa	rtmen tiricat	23/P	ealth a 5dhb 5eath	and M	ental Hy	giene	001	5	37905
	0		1. Decedent's Name (First, Middle,	ast) Raymor	nd Ch	arles	s En	gels:	iepen		2. Date of Do	eath Da	v	Year	3. Time of Death
	Physici /Medic		ZATRIOND C	harles			٠ - سن	0 4	ripi	-, ı J	OCTOB		-	005	17 00 M
	Examin		4a. Facility Name (If not institution, g	rive street and number)					Location				. County of altin		
			JOHNS HOPKIN					A LT	If Under		LITY				1 (Ot-1 F
п	Funeral		5. Social Security Number 6 208-32-6632	.Sex 7.Aga 1.2XM 2.☐F	e (In yrs. Ias 62	st <i>Dirthday)</i> Yrs.	Months		Hours	Min.	8. Date of Bi	ay Year)	1	9. Birtnp Coun Penn	lace (State or Foreigi etry) Sylvania
	Director		Usual Residence of Decedent								3/0/1.	713			Syrvania
	iand ow		10a. State 10b. County		10c. City,	Town or Lo	cation							1	0d. Inside City Limits
	Mary -1 sh	ţ	DE Kent		Har	tly									1 ☐ Yes 2 🖾 No
	s with the	Funeral Director	10e. Street and Number 2370 Arthursvill	le Road			10f. Zip	Code 1995	3			10g. Ci	tizen of W	hat Coun	itry?
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If item 27 is marked other then "natural", or Items 23a or 28e-f show importent: If item 27 is marked other then "natural", or Items 23a or 28e-f show styl hjurty or other treumatic event, I've Modical Exam natural ce notified at once.	þ	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 1 XYes 2 1 If Yes, Give Year or Dates:			Was Dece If Yes, spe	cify Cuba	ispanic Ori n, Mexicar Specify:	n, Puerto l	cify Yes or N Rican, etc.)	0-		, White,	an Indian, etc. White
9	72 ho	Completed	15. Decedent's (Specify only highest)			16a. Dece	dent's Usu kind of wo	al Occupa	ation during mos	t of workir	na	16b. K	and of Bus	iness/Ind	dustry
7	thin 7	npie	Elementary/Secondary (0-12)	Coltege (1-4or 5	i+) E	ower	DO <u>N</u> OT u	se retired	)		,	Food	d Pro	cess	ing
	ed will yellen yellen yellen the transfer th	Cor	12th								(Final Adiately				
Maryland	uld be fii Vental H irked oth	To Be	Anthony Engelsie						Mild	red H	(First, Middle Kline				
	and 2 sho saith and I n 27 is me		19a. Informant's Name/Relationship Connie Engelsier			19b. Mailir 2370	ag Address Arthi	(Street a	ille	er or Rura Road	Hartly	per, City o	or Town, S E 199	itate, Zip 53	Code)
Baltimore,	permit. Pages 1 and 3 Department of Health Importent: If item 27 eny Injury or other tr once.		20a. Method of Disposition 1 ☐ Burial 2 A Cremation 3 1 ☐ Donation 5 ☐ Other (Spe		cen	ce of Disponetery, crer Crei	natory or o	other plac	rvice		4/2005		ocation - 0 /rna,	-	own, State
Balti	permit. Departn Importe eny Inju		21. Signature of Funeral Service Line	menter MO	1375	20 1	arie 29 S.	s Æü Mair	neral n St.	<sup>ty</sup> Dire Smyı	ectors cna, Di	Inc 199	77		
	Physician /Medical		23a. Part1. Enter the disease, or or shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	ity one cause on each li	ne.	BRAI				cardiac o	r respiratory a	arrest,			Approximate Interval Between Onset and Death / olary
L	Examiner	_	Sequentially list conditions.		HEAR	TF	AILL	ハモ							4 days
	be executed ician and burial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	HEA	RT	ATT	Ack							Tolays
8760,	cate be executed by sician at the burial-	dical Ex	resulting in death) East	Due to (or as	onary		ry Di	seas	:e						
9	ntifica ng ph as th	0	IF FEMALE:												
P.O. Box	requires that the death certificate be executed een signed by the attending physician and nouid be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ②No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal d	eath 3[	∃Ectopic p ∃ Other (sp						23d. Date Mon		ery Day Year
Records, P.	uires that the de n signed by the a Id be detached f	ρ	Part II. Other significant condition	s contributing to death b	ut not result	ing in the u	nderlying o	ause give	en in Part I			tobacco Yes 2			ne cause of death?
000	- 0	iete									24a. Wa:	s an	24b. W	ere auto	psy findings available
l Re	The la ate has page 2	Completed									auto perf 1 Yes	ormed? 2∫2No	de	ior to coreath?	mpletion of cause of 2 No
Vital	ysicien: is certific director,	Be (	25. Was case referred to medical examiner?							of Death	(Check only	one)			
<u>&gt;</u>		2	1 ☐ Yes 2 🔀 No	Hospital: 1 🗷 Inpatie		R/Outpatier			4 🗀 190		ne 5 Res				y)
П	fter	on:	27. Manner of Death  1   Natural 5 □ Pending	28a. Date of Inju (Month, Da	ry y Yea <i>r)</i> 2	8b. Time o Injury		28c. Injun Worl	k?		28d. Describe	how inju	ry occurre	d	
Division of	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the fune	Certification:	2 Accident investiga 3 Suicide 6 Could no 4 Homicide determin	t be		ie, farm, sti	M reet, factor		Yes 2		28f. Location City or To			r or Rura	l Route Number,
Ö	urs afte					lades dost	h	l as the size	- data or	d sloop o				nor 25 cl	tated
	To the Hospitel or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	Medical	29a. Certifier 1 ☐ Certifying (Check only 2 ☐ Medical Ex	Physician: To the best ceminer: On the basis of and manner sta	f examinatio	n and/or in	vestigation	n, in my of	pinion, dea	ith occurre	ed at the time	, date an	d place, ar	nd due to	the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	2			29	c. License	e number			29d. Da	ite signed	(Month,	Day, Year)
)			1347	m -				RES	- DC	0		OCT	OBER	30	, 2005
	127		30. Name and address of person wi	no completed cause of d											
	10		BANTAYEHU S	1 LESHI	600	N. W	DLFE	ST.	, B	ALTIN	TORE	MI	) 21	287	
:	Sta Regist		31. Date filed (Month, Day, Year)	32. Registr	ar's Signatu	re Asia	200								

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 0531 November 17, 2005 Helen Elizabeth Fischer 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death UNION HOSPITAL ELKTON CECIL If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2 K F Yrs 185-05-4866 87 June 27, 1918 Pennsylvania Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No Maryland Cecil Warwick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 73 Cabot Court 21912 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give A Year or Dates: 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Scientific Instrument Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing

Assembler

20b. Place of Disposition (Name of

riomen

23a. Partt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line.

Philadelphia Crematories

18. Mother's Name (First, Middle, Maiden Surname)

20c, Location - City or Town, State Philadelphia,

Maryland 21921

Pennsylvania

ELKTON, MD

Helen Wayne Lee

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

November

21, 2005

73 Cabot Court, Warwick, Maryland 21912

22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton,

Physician /Medical

Department of important; If any injury or once.

Examiner

For State Registra

10a, State

11

17. Father's Name (First, Middle, Last)

19a. Informant's Name/Relationship (Type, Print)

<sup>¹</sup> 4 □ Donation 5 □ Other (Specify)

21. Signature of Funeral Service Licensee

Sandra R. Weber/Daughter

1 ☐ Burial 2 X Cremation 3 ☐ Removal from State

KUSTOGI,

NOV 2

MD

32. Raistrar's Signature

1081451

Ralph Yost

20a. Method of Disposition

Directo

Be Completed by Funeral

2

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

with the Maryland

Pages 1 and 2 should be filed within 72 hours effer death with the Marylar ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28e-f show ury or other treumatic event. The Medical Examiner must be notified at

Baitimore, Maryland 21215-0036

burial-transit efter death. Director: A 24 hours e within 24 ho To the Func

The law requires that the death certificate be executed

Hospitel or Attending

Division of Vital Records, P.O. Box 68760,

HELEN

-ISCHER,

	23a. Parti. Enter the disease, or comp shock, or heart failure. List only	one cause on each line.				Approximate Interval Between
U	Immediate Cause (Final disease or condition	MYOCI	ARDIAL	INFAR	CCTION	Onset and Death
Completed by Physician/Medical Examiner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consect b. Due to (or as a consect b.	quence of): 109Er quence of): 2RTICU	VIC SHOU		
ysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pregn 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of o 9 □ Unknown	al death 3 Ectopic	c pregnancy (specify)		23d. Date of delivery Month Day Year
ed by Ph	Part II. Other significant conditions co	ontributing to death but not re-	sulting in the underlyin	g cause given in Part I.	23e. Did tobacco u	ise contribute to the cause of death?
Complete					24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No
Be (	25. Was case referred to medical examiner?			26. Place of De	ath (Check only one)	
2	1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2	ER/Outpatient 3	DOA Other: 4 Nursing	Home 5 Residence	3 □Other (Specify)
	27. Manner of Death  1 PNatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury	y occurred
Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, street, fac fy)	tory, office	28f. Location (Street and City or Town, State	d Number or Rura! Route Number, )
edicai (	29a. Certifier 1 ☐ Certifying Phy (Check only one) 2 ☐ Medical Exam	ysician: To the best of my kniner: On the basis of examination and manner stated.	owledge, death occurration and/or investigat	ed at the time, date and plac ion, in my opinion, death occ	e, and due to the cause(s) urred at the time, date and	and manner as stated. place, and due to the cause(s)
Ž	29b. Signature and title of certifier	deal		29c. License number		e signed (Month, Day, Year)
	Almer	<del>***</del>		D59398	Nov	ember 17, 200
14	30. Name and address of person who o	completed cause of death (Ite	n 23a) (Type, Print)			-

HOSPITAL

10

State

Registrar

ALOK

31. Date filed (Month, Day, Year)

UNION

			For State Registrar	State of Ma		partment of I ertificate of		nd Mental Hy	giene Reg. NG 005	37907_
ı	Physicia	an	1. Decedent's Name (First, Middle, Last)  MARY ELIZABETH FO	MDV			·	2. Date of Dea	Day Yea	
	/Medic Examin		4a. Facility Name (If not institution, give s			4b. City, Town,	or Location of		4c. County of De	7:00A
	LXamin	61	PRINCE GEORGES HO			CHEVI				GEORGES
	Funeral Director		5. Social Security Number 6. Sex	M XXF 7. Age	a (In yrs. last birthda O I. Yrs.	Months Davs		Min. (Month, Da	th y, Year) 9. B	Birthplace (State or Foreign Country)
			416 26 9350 Usual Residence of Decedent		84 TIS.			JAN. 01	, 1921   AI	LABAMA
	arylan show	2	10a. State 10b. County		10c. City, Town or					10d. Inside City Limits  XXYes 2 □ No
	the M	ecto	MARYLAND PRINCE GE  10e. Street and Number	ORGES	UPPER MA	ARLBORO 10f. Zip Code			10g. Citizen of What	
	h with	IO IE	335 RIDGELY STREET				20774		UNITED S	STATES
ထ္	be filed within 72 hours after death with the Maryland by bydene. I be hydrene of other than "natural", or flema 23e or 28e-f show do ther than "natural", or flema 23e or 28e-f show event, I're Micdical Extended in the natified at	y Funeral Director	XX Never Married 2 Married	12. Was Decedent E Armed Forces? 1 ☐ Yes 🍇 🐧 N If Yes, Give	Ever in U.S. 1.	3. Was Decedent of If Yes, specify Cut		in? (Specify Yes or No Puerto Rican, etc.)	14. Race - Ar Black, WI Specify:	
5-0036	hours tural',	ed by	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Educ	Year or Dates:	16a. De	cedent's Usual Occu	nation		16b. Kind of Busines	
	hin 72 In "na Medic	plet	(Specify only highest grade	College (1-4or 5	(Gi	ive kind of work done  DO NOT use retire	during most	of working	135. King of Edulion	our indicately
2121	filed with Hygiene other the ent, Ine	Completed		2 YRS.		CHER / DON	MESTIC .		GOVERN	MENT
and	e d la b	Be	17. Father's Name (First, Middle, Last) WILLIAM ANDERSON F	OMBY				's Name <i>(First, Middl</i> e, \ MITCHELL	Maiden Sumame)	
Maryland	É DE E	၉	19a. Informant's Name/Relationship (Ty)		19b. Ma	ailing Address (Stree		or Rural Route Number	er, City or Town, State	ı, Zip Code)
	5 5 5 E		JACQUELINE JACKSON	/ DAUGHT		RIDGELY S	STREET		RLBORO, MI	
altimore,			20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ R	emoval from State	cemetery, c	sposition (Name of crematory or other pla		Date	20c. Location - City	
Ē			* 4 □ Donation 5 □ Other (Specify)  21. Sign flure of Funeral Service License		LAKEMONT	CEMETERY 22. Name and Addr		1/12/2005	DAVIDSON	
Ba	permit. Departr Imports any inje		1. 7. Mars	lle		MARSHALL 4308 SUIT	S FUNE LAND R	RAL HOME O ROAD SUIT	F MARYLAND LAND, MD 2	,INC. 0746
Ų,	Pnysician /Medical		23a. Part 1 Enter the disease, or complishock or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	PNEUM	ONIA				rrest,	Approximate Interval Between Onset and Death
,8760,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the buriat-transit	dical Examiner	Sequentially list conditions, if any, leading to intrinsicate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	·,	a consequence of):	AC AR	CHYTH N	11A		
P.O. Box 6	that the death certifica ed by the attending ph detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 Ø No 9 □ Unknown	3c. If yes, outcome 1□Live birth 4□Pregnant at 9□ Unknown	2 Fetal death	3 □Ectopic pregnant 5 □ Other (specify)	су		23d. Date of o Month	delivery Day Year
	quires that n signed b	by	Part II. Other significant conditions con	ntributing to death b	ut not resulting in the	e underlying cause g	iven in Part I.	23e. Did t	12	to the cause of death?  Probably 4 Unknown
Vital Records,	The law requir ate has been s page 2 should	Completed					<u></u>	24a. Was autor perfo	osy prior to ormed? death	autopsy findings available o completion of cause of ?
/ita	Phyaician: The ribis certificate har al director, page	Be	25. Was case referred to medical examiner?	lospital:			thor	of Death (Check only o		
on of	유 두 교	ion: To	27. Manner of Death	1 ☐ Inpatie	ry 28b. Time	e of 28c. Injury	and the same		dence 6 Other (S)	pecily)
Division of	To the Hospitel or Attending I within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injuding, etc	ury - At home, farm, c. (Specify)	street, factory, office	Э	28f. Location (: City or Tou	Street and Number or wn, State)	Rural Route Number,
	he Hospitel n 24 hours a he Funeral I	edical (			f examination and/o			d place, and due to the h occurred at the time,		
	To the within 2 To the complet	Ž	29b. Signature and title of certifier			29c. Licer	nse number		29d. Date signed (Mo	onth, Day, Year)
^	0		Caxon				1347	5	11/8/	
R	(3)		30. Name and address of person who con the state of the s	BIN	4175	N. HAr	150N	CT #203	A BOW	E, MD 201/5
	Sta Regist	ate rar	NOV 0 9 2005	Seem	ar's Signature	medi				

			T = For State Registrar	State of Ma	aryland / Dep <i>Ce</i>		lealth and		iene .g. 2005	37908
	Physici		1. Decedent's Name (First, Middle, Last, Ethel Mae Falwell					2. Date of Deat		3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give Carroll Hospital C			4b. City, Town, or Westmins	Location of Deat	th	4c. County of Death	
	Funeral Director			7. Age ]M 2 <b>∑</b> F	9 (In yrs. last birthday, 86 Yrs.	If Under 1 Year   Months   Days	If Under 24 Hrs Hours Min.		Year) 9. Birth Con 1919 Wash	place (State or Foreign intry) ington, DC
	Maryland a-f show	tor	Usual Residence of Decedent  10a. State 10b. County Maryland Baltimore		10c. City, Town or L Owings N					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	3a or 28	i Dire	10e. Street and Number 9473 Ashlyn Circle			10f. Zip Code 21117			Og. Citizen of What Cou United Stat	5.4
980	be filed within 72 hours after death with the Maryland nat Hygiene. od other then "naturel", or Iteme 23e or 28e-f show event, the Medical Exeminat must be notified at	by Funeral Director		12. Was Decedent E Armed Forces? 1 □ Yes 2 ▼ N If Yes, Give Year or Dates:	Ever in U.S. 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No			14. Race - Amer Black, White Specify: Wh	ican Indian, , etc.
Maryland 21215-0036	within 72 ho ene. than "natur	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e <i>completed)</i> College (1-4or 5	+) (Give	edent's Usual Occup e kind of work done o DO NOT use retired	ation during most of wo	rking	16b. Kind of Business/I	ndustry
land 2	uld be filed within flental Hygiene. rked othar than tic event, I to Me	To Be Co	17. Father's Name (First, Middle, Last) Charles Newton Geo	rge	ПОЩЕ	maker		me (First, Middle, 1 Mae Sanfo	,	
	es 1 and 2 should be of Health and Mental of Itam 27 la marked or other traumatic every		19a. Informant's Name/Relationship (T) Carol A. Wetmore/D		1				City or Town, State, Z	
Baltimore,	a a tr		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	Removal from State	Columbia	osition (Name of omatory or other place a Gardens	20	mber 9,	20c. Location - City or 1 $Arlington$	
Balt	permit. I Departm Importa any injui		21. Signature of Funeral Service Licens	the			Gall	eVol Fune Drive thersburg	ral Home, . Maryland	
	Physician /Medical Examiner		23a. Hart // Inter the disease, or complete with the disease, or complete with the disease or condition resulting in death)	ne cause on each in	ie.	oter the mode of dyin	,		est,	Approximate Interval Between Onset and Death
		Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	o	a consequence of):					
8760,	icate be executed physician and s the burial-transit	cai	resulting in death) Last	Due to (or as a	a consequence of):					
P.O. Box 6	The law requires that the death certificate be executed the has been signed by the attending physician and orge 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 ☐ Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of deli Month	very Day Year
	w requires that been signed b should be deta	by	Part II. Other significant conditions co			underlying cause giv	en in Part I.		pacco use contribute to es 2 ĒNo 3 ☐ Pro	
Vital Records,		Completed						24a. Was a autops perform	v prior to c	opsy findings available ompletion of cause of
Vita	Physiclan: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:	/	Oth		ath (Check only on	(8)	
of	ling After fune	tion; To	1 Yes 2 TNo '  27. Manny of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	v 28b. Time	of 28c. Injur Wor	4   Nursing I	7	ence 6 Other (Spec ow injury occurred	ify)
Division	p # in in	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injubul	ury - At home, farm, s c. (Specify)	treet, factory, office		28f. Location (St City or Town	reet and Number or Ru n, State)	ral Route Number,
	To the Hospital or within 24 hours after To the Funaral Discompletely filled in	Medical (	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exemi	sician: To the best oner: On the basis of and manner sta	examination and/or in	th occurred at the tin nvestigation, in my o	ne, date and place pinion, death occ	e, and due to the caurred at the time, d	ause(s) and manner as ate and place, and due	stated. to the cause(s)
	Fit	2	29b. Signature and title of certifier			29c. Licens	9806		9d. Date signed (Month	, Day, Year)
	¥ 10		30. Name and address of person who co Patrick Turnes, M.	The state of the s		•	102, Syk			
	Sta Regist		31. Date filed (Month, Day, Year) NOV 0 8 21	32. Registra	ar's Signature	onetis				

DHMH 17 Rev 1/2001

ETHEL

			1- State of Maryland	-	irtment of l			2000	07000
			Registrar  1. Decedent's Name (First, Middle, Last)		incate of	Death	2. Date of De	Reg. No. UU	3. Time of Death
	Physicia /Medic		William Preston Fleming				111	3 2005	6:35 P M
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town,		of Death	4c. County of De	
Mr.	Funeral		10102 Silver Point Lane 5. Social Security Number 6. Sex 7. Age (In yrs. last	t birthday)	Ocean If Under 1 Year		24 Hrs. 8. Date of Bit	Worcester	
	Funeral Director		220-34-7519 1 <sup></sup> XM 2 <sup></sup> F 81	Yrs.	Months Days		24 Hrs. 8. Date of Bit 10/15/	1924	irthplace (State or Foreign Country) MD
and	*		Usual Residence of Decedent           10a. State         10b. County         10c. City, T	own or Lo	cation				10d. Inside City Limits
with the Maryland	-f sho	tor		ean (					1 X Yes 2 No
the the	r 28a	Irec	10e. Street and Number	- Curi	10f. Zip Code			10g. Citizen of What C	Country?
Ť.	23a o	al D	10102 Silver Point Lane		2184	2		USA	
-UU36 hours after death	or Its	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes, Give Year or Dates:		Vas Decedent of f Yes, specify Cub		igin? (Specify Yes or No n, Puerto Rican, etc.)	0	ite, etc.
215-0036 bin 72 hours af	2.74	ed b		6a. Deced	lent's Usual Occu	pation		16b. Kind of Busines	/hite s/Industry
Within 72	an "na	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give life. (	kind of work done OO NOT use retire	during mos ad)	at of working	1	amoustry
<b>N</b> 7	Hygien other th		10	P	lumber	1		Plumbing	
and gang	\$ 0 th	Be c	17. Father's Name (First, Middle, Last) William Fleming			18. Mothe	er's Name <i>(First, Middle</i> Lillian Wo		
aryla should	and Me is mark sumati	2		19b. Mailin	g Address (Stree	t and Numbe		per, City or Town, State,	Zip Code)
; Ma	ニトド						Lane, Oce	an City, MD	21842
<b>0</b> -	of H itan		20a. Method of Disposition 1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State	e of Dispo etery, cren	sition (Name of natory or other pla	ace)	Date	20c. Location - City of	r Town, State
altimor	lant		`4 □Donation 5 □Other (Specify) Cape		lopen Cr		11/7/2005		
Dan J	Departi Importa any Inju		21. Signaturo Frieral Invice Licensee	10	)8 Willia	am St.	, Berlin, I		Home
			23a. Part I. Enter the disease, or complications that caused the death. I shock, or head failure. List only one cause on each line.	Do not ente	or the mode of dy	ing, such as			Approximate Interval Between Onset and Death
	ny.sician Medical		Immediate Cause (Final disease or condition resulting in death)	1146	tic !	> (as	dder (	Hanon	1 C
	xaminer		Due to (or as a consequer	ice of):	. /	4.	17	. 0	
		ner	Superitally list conditions if any, leading to immediate cause. Enter Underlying	ice of):			1 -		
acuted	and transi	Examin	Cause (Disease or injury that initiated events c.						
8/6U,	physician and fhe burial-transit		Due to (or as a consequent	ice of):					
		edical	d						
O. BOX of	by the attending rached for use as	clan/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of deat 9 □ Unknown	ath 3	Ectopic pregnand Other (specify)			23d. Date of do Month	elivery Day Year
ר בּּ	ed by	/ Physl	Part II. Other significant conditions contributing to death but not resulting	ng in the ur	iderlying cause gi	ven in Part I	. 23e. Did	tobacco use contribute	to the cause of death?
ords	been sign should be	ted by					1_	Yes 2□No 3□F	Probably 4 🛣 Unknown
I Records, P	(0	Completed	<u></u>			·	24a. Was auto pend 1 □ Yes	s an 24b. Were a prior to death?	
OT VITAI	certificate rector, pag	Be	25. Was case referred to medical examiner?		0:		of Death (Check only		
O A	r this aral di	To :	27. Manner of Death 28a. Date of Injury 28	b. Time of	t 3 □ DOA 28c. Inju			idence 6 Other (Sp	ecify)
<b>101</b>	nth. r: After e funer	atlor	1 X Natural 5 □ Pending (Month, Day Year) 2 □ Accident investigation	Intury	Wo	ork? ]Yes 2. ☐			
DIVISION of or Attanding	after death Diractor: d in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Ptace of tnjury - At home building, etc. (Specify)	e, farm, str	eet, factory, office			(Street and Number or F wn, State)	Rural Route Number,
DIVISION To the Hospital or Attanding	within 24 hours of To the Funeral completely filled	edical (	29a. Certifier (Check only one)  1X Certifying Physician: To the best of my knowle 2 Medical Examiner: On the basis of examination and manner stated.	idge, death and/or inv	occurred at the trestigation, in my	ime, date ar opinion, dea	nd place, and due to the th occurred at the time,	cause(s) and manner a date and place, and du	as stated. ue to the cause(s)
Ę.	within 2 To tha complet	Ž	29b. Signature and title of certifier		29c. Licen	se number		29d. Date signed (Mor	nth, Day, Year)
<b>L</b>			> Turadin of alley	u	D3074	-3		November 8	3, 2005
C,	H.6		30. Name and address person who completed cause of death m 23 Benjamin H. Meyers, M.D. 400 East	stern	shore Dr	., Sa	lisbury, MD	21804	
Do *	Sta Registr		31. Date filed (Month. Day, Year) 9 2005 32. Jegistrar's Signatur	A	nede				

Registrar DHMH 17 Rev 1/2001

		1 - For State Registrar	State of Ma	-		of Health and of Death	R	eg. Ne2 0 0 5	37910
Physic /Medi		1. Decedent's Name (First, Middle Charles Ra	dle, Last) aymond Gree	r, Sr.			2. Date of Deat Month NOV •	18, 2005	3. Time of Death 8:16 A M
Exami Funeral Director	ner	4a. Facility Name (If not instituting 11 Christ Hospice Cast) 5. Social Security Number 213-34-6452	are	e (In yrs. last birti Y	Te	own, or Location of Deat  OWSON  Year If Under 24 Hrs  Days Hours Min.	. 8. Date of Birth	4c. County of Dea Baltimo 2,1938 Te	
1		Usual Residence of Decedent 10a. State 10b. Coun		10c. City, Town	or Location				10d. Inside City Limits
the Marylan r 28a-f show	ctor	PA Yorl	ζ	New I	reedom				1 ☐ Yes 2X No
	ai Dire	10e. Street and Number 289 Hillton	Court		10f. Zip (	17349		Og. Citizen of What C	ountry?
urs after ai', or ite	by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorce	If Yes, Give		13. Was Decede If Yes, speci	ont of Hispanic Origin? (S fy Cuban, Mexican, Puer No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Am Black, Whi Specify: V	
n "netur Nedical	Completed	15. Decede (Specify only high Elementary/Secondary (0-12	ent's Education nest grade completed)  College (1-4or 5		Decedent's Usual (Give kind of work life. DO NOT use	Occupation done during most of wo retired)	rking	16b. Kind of Business	/Industry
Hygiene Hygiene ther the		12 17. Father's Name (First, Middle		· I	Firefig		me (First, Middle, I	Governme Maiden Sumame)	ent
Mental arked o	To Be	David Gree					Holt		
is a rain a should be into whill it a rain it a rain it a rain a should be into the mature other transition.		19a. Informant's Name/Relation  Judith Hope		e 28	39 Hill	Street and Number or R top Court	, New Fr	ceedom, PA	17349
Department of Himportant: If item any injury or other		4 Donation 5 Other			Disposition (Namy, crematory or other Cer  22. Name and		05 <sup>21</sup> , J. Harter	20c. Location - City of New Freed Instein Moi	om, PA rtuary,Inc
hysician /Medical	ž	23a. Part1. Enter the disease, shock, or heart failure. Li Immediate Cause (Final disease or condition resulting in death)	or complications that caused ist only one cause on each li	ne.		of dying, such as cardia			Approximate Interval Between Onset and Death
physicien and streamsit transit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Qua to (or as	a consequence of a consequence of	đ):				
y the attending particles as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death	3 □Ectopic pre 5 □ Other (spe			23d. Date of de Month	elivery Day Year
Physician: The law requires that the death certif this certificate has been signed by the attending ral director, page 2 should be detached for use as	þ	Part II. Other significant cond	itions contributing to death be 2 my + Lo	_	the underlying ca	use given in Part I.	23e. Did to	bacco use contribute t es 2 □ No 3 □ P	to the cause of death?  Probably 4 □Unknown
To the Hospital or Attending Physician: The law requir within 24 hours after death.  To the Funaral Director: After this certificate has been si completely filled in by the funeral director, page 2 should	Completed						24a. Was a autops perform	sy prior to med? death?	autopsy findings available completion of cause of s 2 No
cian: sertifica	Be	25. Was case referred to medi examiner?	Hospital:	2000		Other	eath Check only or		11
fter ne	tion; To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pen	1 ∐ Inpati 28a. Date of Inju	ent 2 ER/Ou ury 28b. T ay Year) II		A 4 Nursing  3c. Injury at Work? 1 Yes 2 No		ence 6 Oother (Spoow injury occurred	301ty) (105/14
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification;	2 Accident Inve	ld not be 28e. Place of In	jury - At home, fa tc. (Specify)	rm, street, factory,		28f. Location (S. City or Town	treet and Number or F n, State)	Rural Route Number,
e Hospita 24 hours e Funaral letely filled	edical C		ying Physician: To the best al Examiner: On the basis of and manner st	of examination an					
To th withir To th comp	Me	29b. Signature and title of cert	Trong Rely	ms		DJ5705		19d. Date signed (Mon	118,2005
20		30. Name and address of pers	on who completed color of	death (Item 23a)	(Type, Print)	Charles S	7. Bal	to md	21708
	20 B	31. Date filed (Month, Day, Ye	4	rar's Signature	A				

		1 - For State Registrar	State of Marylar		artment of I			pien 2005	37911
Physic /Medi Exami	cal	Decedent's Name (First, Middle, Last)     ARPHELIUS PAUL GAT     4a. Facility Name (If not institution, give street)	et and number)			or Location of Death	2. Date of Dea Month NOVEMB	Day Year ER 04, 200	5 3:26P M
Funeral Director		220 12 1019	PITAL CENTE  7. Age (In yrs.  5	last birthday)		VERLY  If Under 24 Hrs.  Hours Min.	8. Date of Birth (Month, Day MAY 21	PRINCE 9. Bi	GEORGES  outhplace (State or Foreign Country) SHINGTON, DC
ith the Maryland or 28e-f show	Director	Usual Residence of Decedent  10a. State 10b. County  DC  10e. Street and Number		ity, Town or Lo			1	log. Citizen of What C	10d. Inside City Limits  XXYes 2 □ No  Country?
72 hours after death with the Maryland netural; or Items 23e or 28e-f show or Examine in ust be notified at	Funerai	1 Never Married XX Married	Was Decedent Ever in U Armed Forces? 1 ☐ Yes XXNo If Yes, Give			10019 Hispanic Origin? (Span, Mexican, Puerto	ecify Yes or No- Rican, etc.)		ite, etc.
	Completed by	3 Widowed 4 Divorced  15. Decedent's Educat (Specify only highest grade of Elementary/Secondary (0-12)	Year or Dates:	16a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retire			16b. Kind of Business	
jes 1 and 2 should be filed within of Health and Mental Hygiene. If item 27 is marked other then "or other treumatic event, Ite M.	To Be Co	17. Father's Name (First, Middle, Last)  ARPHELIUS GATLING,  19a. Informant's Name/Relationship (Type,	JR.			18. Mother's Name	SARAH H	Maiden Sumame)	
Pages 1 and 2 s nent of Health ar nt: If item 27 Is nry or other treu		LINDA E. GATLING /  20a. Method of Disposition  XX Burial 2 Cremation 3 Rem	WIFE 20b.	83 5	4TH ST., osition (Name of matory or other pla	SE WA	SHINGTO	N, DC 2001 20c. Location - City o	9 r Town, State
permit. Page Department of Importent: If any Injury or once.		21. Signature of Furneral Service Licensee  23a. Part. Enter the disease, or complicat	lel	2	2. Name and Addre MARSHALI 4308 SUT	'S FUNERA TLAND ROA	L HOME (	SUITLAN OF MARYLAN LAND, MD 2	D, INC. 0746
Physician /Medical Examiner		shook or heart failure. List only one of Immediate Cause (Final disease or condition resulting in death)	ACUTE MYO  Due to (or as a consec	CARDIA:	L INFARCT		ог геориалогу атг	est,	Approximate Interval Between Onset and Death
ate be executed tysician and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d	Due to (or as a consect HYPERCHOL Due to (or as a consect	quence of): ESTERO					
The law requires that the death certific to has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	If yes, outcome of pregn 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	al death 3[	□Ectopic pregnanc □ Other (specify) _	у		23d. Date of de Month	elivery Day Year
w requires that been signed b	by	Part II. Other significant conditions contrib	outing to death but not re	sulting in the u	ınderiying cause gir	ven in Part I.	1 🗆 Y		to the cause of death? Probably 4 □Unknown
	Be Completed	RENAL FAILURE HYPERTENSION 25. Was case referred to medical examiner?				26. Place of Deatl		gy prior to med? death? XX No 1 ☐ Ye	
To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certification completely filled in by the funeral director,	ertification: To E	1 Yes XX No  27. Manner of Death XX Natural 5 Pending investigation investigation	pital: XX Inpatient 2 [ 28a. Date of Injury (Month, Day Year)  28e. Place of Injury - At I building, etc. (Speci	28b. Time of Injury	of 28c. Inju. Wo. M 1	ry at rk? Yes 2 □ No	28d. Describe ho	ence 6 Other (Spow injury occurred treet and Number or Fig. 1, State)	
To the Hospitel within 24 hours a To the Funerel Completely filled	edical Ce	29a. Certifier XX Certifying Physici (Check only one) 2 Medicel Exeminer	ien: To the best of my kn ': On the basis of examin and manner stated.	owledge, deat ation and/or in	th occurred at the ti	me, date and place, opinion, death occurr	and due to the caed at the time, d	ause(s) and manner a ate and place, and du	is stated. e to the cause(s)
Totl Comp	M	29b. Signature and title of certifier  Abela Secure  30. Name and address of person who comp	oleted cause of death (Ite	m 23a) (Tvpe		847	2	9d. Date signed (Mon	

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) NOV 0 9 2005

ROBERT DELAPENHA, M.D.

3001 HOSPITAL DRIVE

CHEVERLY, MD

Baltimore. Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

			•	icuse i								•		Legible.		
			For		State of M	arylan					nd Me	_	_	And the Street	0701	0
			- State Registrar				Ce	rtificate	of D	eath			Reg. No.	002	3/91	6
	Dhusisi		1. Decedent's Name (First	"Middle, Last)				2 . 1)	0.			<ol><li>Date of De Month</li></ol>	ath Day	Year	3. Time of De	
	Physici /Medic		10	seph	E	,	(0	-riff	-in			11	3	05	3:30 1	PM
	Examin		4a. Facility Name (If not ins	stitution, give s	street and number)			4b. City, To	wn, or Lo	ocation of	Death			County of Deat	h	
		а	Charlotte	Hall 1	Elevans 1-	OME		Charle	140	HALL	GNN.		S	T. MA	·V's	
	Funeral		5. Social Security Number	6. Sex	7. Aç		ast birthday)	If Under 1	Year I	If Under 2 Hours	4 Hrs. Min.	8. Date of Bir				oreign
	Director	1	214-16-7658	1 <b>X</b> .	M 2□F   {	35	Yrs.	WORKIS	Jays	Hours	WIII I.	8. Date of Bir (Month, Da July 5	,192	0 Vir	hplace (State or Fo untry) ginia	
	p ,		Usual Residence of Deced			1.0										
	aryla shov	line .	10a. State 10b. (	County			y, Town or Lo								10d. Inside City L	
	9 Mg	cto	Maryland Ch	narles		Ind	ian He	ad							1 Tes 2	X No
	는 15 12 12 13 13 13 13 13 13 13 13 13 13 13 13 13	Oire	10e. Street and Number					10f. Zip C					_	zen of What Co	untry?	
	within 72 hours after death with the Maryland ene. than "netural", or tieme 23a or 28e-f show the Medical Examinar must be notified at	by Funeral Director	18 Irving P					206	40				U.S	.A.		
	r des	ne	11. Marital Status		<ol><li>Was Decedent Armed Forces?</li></ol>	?	S. 13.	Was Deceder	nt of Hisp	anic Orig	in? (Spec	cify Yes or No lican, etc.)	)~	14. Race - Ame Black, Whit		
36	or it	ΥF	1 Never Married 2[		1 Tyres 2 If Yes, Give	No	-	1 Yes 2		Specify:				Consider		
215-0036	ural	q p	3X Widowed 4 □ Di		Year or Dates:									AATT	ite	
Ŋ	net dis	ete	15. De (Specify only	ecedent's Edu <i>high</i> es <i>t grad</i> e	cation e <i>completed)</i>		(Give	dent's Usual ( kind of work	done dur	on ring most	of workin	g	16b. Ki	nd of Business/	Industry	
12	withir than	Completed	Elementary/Secondary (	0-12)	College (1-4or	5+)		DO NOT use					TT C	C		
121	filed withi Hygiene. sther than		17. Father's Name (First, A	Middle Last)			Leac	ling Ma		9 Mothor	de Namo	(First, Middle		. Gover	ment	
ano	ould be 1 Mental I arked o atic eve	Be	_		fi.									Juname)		
$\equiv$	d Men narks natic	L C	James  19a. Informant's Name/Re	Grif			40h 44-111			Ali		Lovel		T 0:	-	
Maryland	s 1 end 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene if Health and Mental Hygiene (Itam 27 is marked other than "netural", or iteme 23a or 28e-1 show other traumatic event, I'm Medical Examinar marities notified at		Allen A. Gri		_		1	-						r Town, State, 2	up Code)	
_	1 end Healt am 2 ther		20a. Method of Disposition		Son	20h P	- In the second					rf, Md		cation - City or	Tours State	_
Ö			1 XBuriai 2 ☐ Crem	nation 3 🗆 R	lemoval from State	C	emetery, crei	matory or othe	er place) -	Nov.	7,2			orf, Ma		
Ë	tant tant		`4 □Donation 5 □ O			Tr	inity	Memori	ar G	arde	ns			,		
Baltimore	permit. Peges 1 end 3 Department of Health Important: If itam 27 any Injury or other tra 2002.		21. Signature of Funeral S		///_	10000	o V	illiam	Address of Fu	of Facility Inera	l Ho	me, P.	A.			
	J □ = 2 04		23a. Part1. Enter the diversion of the shock, or hear far un	full	ung !	40066	8 4	270 Ha	wtho	rne	Rd.,	India	n He	ad, Md.	20640	
			23a. Part1. Enter the dife shock, or heart farur	ase, or compli e. List only or	ications that cause ne cause on each l	d the death ine.	n. Do not en	er the mode of	of dying, :	such as c	ardiac or	respiratory a	rrest,	35	Approximate Interval Betwee	
	Physician		disease or condition		101	07-1	Ac	han 1	101	11					Onset and Dea	.tn
	/Medical		resulting in death)		Due to (or as	a consequ	uence of):									- 1
	Examiner		Sequentially list conditions		11	100	ters	<b>-</b>								
	p =	ner	Sequentially list conditions if any, leading to immediat cause. Enter Underlying	te	Due to for as	consequ	uence of):	4.6								
	nd	Examiner	that initiated events	,	, K	17-1	IN	100	CH							
0	te be executed ysicien and ie burial-transit	Ë	resulting in death) Last		Due to (or as	a consequ	uence of):									
3760,		Ical			d											
99	deeth certifica e attending ph od for use as th	Ved	IF FEMALE:													
Вох	th ce tendi	an/I	23b. Was decedent pregn	anı	3c. If yes, outcome 1 ☐ Live birth			Ectopic preg	nancv				2	23d. Date of del		
	0 0	sici	in the past 12 months	57	4☐Pregnant a 9☐Unknown	t time of de	eath 5	Other (spec	ify)					Month	Day Year	r
P.0	at the	hy	9 Unknown													_
	requires that the death een signed by the atte hould be detached for	by Physician/Med	Part II. Other significant of	onditions cor	ntributing to death t	out not resu	Λ		se given	in Part I.					the cause of death	
Records,	w require been signature	ted	DIA by	ry 1	WILL	<del>                                     </del>	10/10	4~/	Vall	(-1~		10	Yes 2[	□No 3□Pr	obably 4 Dunkr	nown
ပ္ထ		ple	Alle									24a. Was		24b. Were au	topsy findings ava-	Hable
	sicien: The law certificete has b irector, page 2 s	Completed	,									perfo	rmed?	death?		6 01
of Vital	rtiffice	0	25. Was case referred to	medical					2	26. Place	of Death	(Check only o				
>	Physicien: this certific ral director,	To B	examiner?	H	lospital: 1 🗌 Inpati	ent 2 🗆	ER/Outpaties	nt 3 DOA	Other:	4 Nur	sing Hom	ie 5 ☐ Resi	dence 6	S □Other (Spec	cify)	
0	ig Ph		27. Manner of Death	Dandina	28a. Date of Inju (Month, Da	ury av Year)	28b. Time o	f 28c	: Injury at Work?			8d. Describe				
Division	ath. or: Af	atlo	2 Accident	Pending investigation		,		М		s 2 🗆 N	lo					
<u>S</u>	ar de recto	tiflo	3 ☐ Suicide 6 ☐ 4 ☐ Homicide	Could not be determined	28e. Płace of In	jury - At ho	me, farm, st	reet, factory, o	office		2	8f. Location (	Street an	d Number or Ru	ıral Route Number,	
	rs eft	Certification;			3	(۵, 20)	,,					0.1, 0	,,			
	To the Hospital or Attending Physicien: within 24 hours effect death.  To the Funerel Director: Affect his certific completely filled in by the funeral director.	ca	29a. Certifier 1.2C	ertifying Phys	sicien: To the best ner: On the basis of	of my know	wledge, deat	h occurred at	the time,	, date and	place, a	nd due to the	cause(s)	and manner as	stated.	
	the H the F plete	edical	one)		and manner s	ated.	tion and/or in				- OCCUITE	u at the time,	uate and	place, and due	to the cause(s)	
	To To I	Σ	29b. Signature and title of	certifier	11			29c. l	icense n	number	/ -		29d. Dat	e signed (Monti	h, Day, Year)	
•			1/1/	111					000	610	197		11/	3/11		
			30. Name and address of	person who co	Die a		23a) (Type,	Print) 29	44	e) !	Ohe	ylotte	? He		Charlotte	
	DB3?		Dr. Mat	nur,	Man		C	-harlo	He	Hal	1 up	teran	is He	one 1	172062	12
9	Sta		31. Date filed (Month, Day		32. F gist	rar's Signa	turg	-harlo								
	Regist	rar	NO/	1 0 7 20	DAD LANG		~ /7									

			State of Maryland / Department of Health a  1- State Registrer  Certificate of Death		/1	105	37913
7		魚 -	Registrar  1. Decedent's Name (First, Middle, Last)	2. Date	Reg. No.		3. Time of Death
	Physici		Kendall Wayne Grote	Nov.	02, <sup>Day</sup> 200!	Year 5	12:39P M
	/Medic Examir		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of			nty of Death	
		29	Civista Medical Center La Plata		Char	rles	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 1 180 – 20 – 2086 Yrs. 78 Yrs. 16 Under 1 Year If Und	Min. 8. Date (Mont	of Birth h, Day, Yaard ry 15,1	9. Birth	place (State or Foreign
	Director		180 - 20 - 2086 X 2 78 Yrs. World Says Trous	reprua	ry 13,1	321	PA
W	yland		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
10	ith the Marylar or 28a-f ehow	ctor	MD Charles La Plata				1 ☐ Yes 🏋 No
ROT	or 28	Dire	10e. Street and Number 10f. Zip Code		10g. Citizen o		intry?
60	rs after death with the Maryland , or itema 23a or 28a-f ehow seminer must be notified at	by Funeral Director	5262 Carmelite Drive 20646		US		
` 10	ter de	Fune	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 □ Married  1 □ Yes X □ No  1 □ Yes → X □ No	n, Puerto Rican, etc	or No- 14. H	ace - Ameri lack, White,	etc.
338	hours after tural', or ite	by	If Yes, Give  Year or Dates:  If Yes Give  Year or Dates:  1 ☐ Yes 2 No Specify:		Spec	oify: WI	nite
, ıçı	72 hours "natural",	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most life. DO NOT use retired)	t of working	16b. Kind of	Business/Ir	ndustry
121	S - 40	mpi	Elementary/Secondary (0-12) College (1-4or 5+) Frinciple		High	Sch	201
420		ပိ		er's Name (First, M			301
lan	buid be filed Mental Hygi arked other atic event, I	To Be		tle Gri			
ary	2 should be filed and Mental Hygi ie marked other aumatic event, I	<b>)</b> -	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number	er or Rural Route N	umber, City or Tow	n, State, Zi,	o Code)
DIE.	ges 1 and 2 should t of Health and Men If item 27 le marke or other traumatic		Ann Benbow/Daughter 10369 Andrea La		lata,MD	206	46
	Pages 1 nent of Hi int: If iten		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  ZBurial 2 □ Cremation 3 □ Removal from State	Date 7.1 / 1	20c. Location		
$K_{\ell}$ Baltimore	t. Partmen		4 Donation 5 Other (Specify)				
Bal	permit. Pages Depertment of I Important: If its eny injury or o		21. Signature of Funeral Service Licensee M00945  P.O. BOX 56				
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as shock, or heart failure. List only one cause on each line.	cardiac or respirate	ory arrest,		Approximate Interval Between
<b>6</b> %	Physician	0	Immediate Cause (Final disease or condition resulting in death)  a. CVMISMYS for the 150 resulting in death)	henri			Onset and Death
	/Medical Examiner		Due to (or as a consequence of):				
1 (A)		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	12918			geers
	uted d ansit	Examiner	cause, Enter Underlying Cause (Disease or injury that initiated events c.				
ó	ate be executed hysicien and the burial-transi		resulting in death) Last Due to (or as a consequence of):				
8760,	cate be executed by sicien and the burial-transit	dicai	d				
9	ding p	/Mec	IF FEMALE: 23b. Was decedent program: 23c. If yes, outcome of pregnancy				
Вох	that the death certifii ed by the attending p detached for use as	cian	23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☑ No  1 ☐ Yes 2 ☑ No			Date of delive Month	ery Day Year
0.	it the d by the tached	hysi	9 ☐ Unknown				
o.	Attending Physician: The law requires that the death certific rideath. ector: Atter this certificate has been signed by the attending p by the funeral director, page 2 should be detached for use as	Completed by Physician/Me	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	. 23e.	Did tobacco use co	ntribute to t	he cause of death?
ord	w requires been sign should be	ted	Chronic renal failure		1. Yes 2 □ No	3 🗌 Prob	pably 4 □Unknown
ec	e lawr has be je 2 sh	npie			autopsy	prior to co	opsy findings available impletion of cause of
표	ysician: The lavis certificate has director, page 2			1 🗆 Y	es 2.2 No	death?	2□ No
Vit.	sician: Th certificate rector, pag	Be	examiner?	of Death (Check o			
ō	Phys or this oral di	To :	1 Napore of Death 1 Natural 5 Pending (Month, Day Year)  1 Inpatient 2/D ER/Outpatient 3 DoA Care: 4 Nur 27. Mapner of Death 1 Natural 5 Pending (Month, Day Year) 28b. Time of Injury Work?	rsing Home 5 28d. Desc	Residence 6 00		(y)
<u>io</u>	nding ath. r; Afte	atlor	1 Anatural 5 ☐ Pending (Month, Day Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ N		,,		
Division of Vital Records, P.O.	after death after death Director;	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		on (Street and Num r Town, State)	nber or Rura	al Route Number,
D	urs afte rai Dir	Cer	V				
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: Atter th completely filled in by the funeral	edicai	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and concerned on the basis of examination and/or investigation, in my opinion, deat and manner stated.	d place, and due to th occurred at the t	the cause(s) and r me, date and place	nanner as s , and due to	tated. the cause(s)
_	within To the compl	Me	29b. Signature and time of certifier 29c. License number		29d. Date sign	ied (Month,	Day, Year)
			D-33426		11-2	-05	
(	416		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)				
(	0610		B. Larry Jenkins, MD 111 LaGrange Ave P.O.Box 2665 31 Date filed (Month, Day, Year) 32 Registrar's Signature	5 La Plat	a, MD 206	i46	
6	Sta Registr		NOV 0 7 2005 Museu & Species				

State of Maryland / Department of Health and Mental Hygiene

		Decedent's Name (First, Middle, La		(	Certificate of	Death	Reg	1 Son .	05 3	7911
Physi	cian	Michael	Hiven	Gu	yer		2. Date of Death Month	Day	Year 3:	Time of Death ""
	dical	4a. Facility Name (If not institution, giv			.,,,,,	4b. City, Town, or Lo	November ocation of Death	4. County		:15 AM
Exan	iner	Knollwood Manor		enter		Millersv			e Arund	le1
Funera Directo		214-72-3030	ex 7.Age ZAM 2□F	(In yrs. last birthe	Months Day	r If Under 24 Hrs. s Hours Min.	8. Date of Birth (Month, Day.) March 16	, 1957	9. Birthplace Country) Washin	(State or Foreign
and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location				10d II	nside City Limits
Maryl f sho	ច្ច	Maryland St. Ma	ry's	•	chanicsvil	1.0				☐ Yes 2 No
r 28a	Director	10e. Street and Number	ily S	net	10f. Zip Code	Te	100	. Citizen of V	Vhat Country?	<u> </u>
th with		29826 Adams Road	L		206	59		U	S A	
<b>BEITIMORE, MARYIBING 21213-UU2U</b> permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other then "natural", or thems 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ②N If Yes, Give Year or Dates:	ever in U,S.	13. Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 🛣 No		ecify Yes or No- Rican, etc.)	Blac	e - American In k, White, etc. : White	
2-to 72 hc 72 hc	ete	15. Decedent's Ed (Specify only highest gra	ducation de completed)	16a. D	ecedent's Usual Occu	pation a during most of work	ina 16	6b. Kind of Bu	siness/Industr	у
Mary State of Mary 12 12 12 12 12 12 12 12 12 12 12 12 12	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	+)	Give kind of work done fe. DO NOT use retir	ed)		_		
Hygie Thert		12 17. Father's Name (First, Middle, Last)			Salesman	18 Mother's Name	e (First, Middle, Ma		alershi	Ĺp
d be defended by the contract of the contract	To Be			Guyer		France		lores	<sub>е)</sub> На]	11
shoul nd M	F	19a. Informant's Name/Relationship (		-	Mailing Address (Stree					
and 2 alth a alth a 27 is	1	Joy T. Guyer/ Sp	oouse		326 Adams					
DAILIMOTE, INITYIANG ZIZIS-UUZU semit. Pages I and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. mportant: If Item 27 is marked other than "natural", or nny injury or other traumatic avent, the Medical Evani		20a. Method of Disposition 1 □ Burial 2 ☐ Cremation 3 □ 4 □ Donation 5 □ Other (Specification 1)			isposition (Name of crematory or other place 1d-Echol		IOV 20Hs		City or Town, S	
mit.		21. Signature of Funeral Service Licen	ISBE (			ress of Facility 1d-Echols				,
D 8855	3	Horn BA	100			128, Char				20622
		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused to	the death. Do not					App	roximate rval Between
Physicial /Medica Examine	l r	immediate Cause (Final disease or condition resulting in death)	b	Oue to (or as a co	nsequence of):	LURE	ACU TE	+ CHJ	Conk,	Hours
A CO / CO / entificate be executed ing physician and e as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	c	Oue to (or as a cor	rsequence of):				1	
A CO / CU, entificate be ex ding physiclan as	ĮΣ	that in Mated events resulting in death) Last	d.	ue lo (oi as a coi	sequence of):					
attenc for us	cian			13-3						
that the death cert ed by the attendin detached for use	Physician/	Part II. Other significant conditions or	ontributing to death but	t not resulting in th	e underlying cause g	iven in Part i.	23b. Did toba	1.6		cause of death?
aw requires s been sign 2 should be	Completed by						24a. Was an a performe		available	utopsy findings e prior to tion of cause ?
The law ate has t	Į						1 ☐ Yes	2 No	1 ☐ Yes	2 □ No
VILC clan: entific ector,	B	25. Was case referred to medical examiner?	IIh-l			26. Place of Death	(Check only one)			
hysle this c	2	1 les 2/20	Hospital: 1 ☐ Inpatien		tilent 3L DOA		me 5 Residence			
Affer funer	ig ig	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day	Year) 28b. Tim Inju	ry Wo	iryat ork? ]Yes 2 □No	28d. Describe how	injury occurre	∍d	
I or Attending Physician: after death. Director: After this certific d in by the funeral director,	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined		y · At home, farm (Specify)	, street, factory, office		28f. Location (Stree City or Town, S		or or Rural Rou	te Number,
To the Hospital or Attending Physician: The is within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical C	29a. Certifier (Check only one)  1 Certifying Phyone	ysician: To the best of niner: On the basis of e and manner state	examination and/o	eath occurred at the tr r investigation, in my	ime, date and place, a opinion, death occurre	and due to the caused at the time, date	se(s) and mar and place, a	nner as stated. nd due to the c	cause(s)
Velthi To the	ž	29b. Signature and title of certifier	101	, -		se number			(Month, Day,	
		1 Dmile	Willau	i (m)	D:	31136	<b>/</b> /	OVEM	BER 4	,2005
22		30. Name and address of person who	completed cause of dea	ath (Item 23a) (Ty	pe, Print)	31136 bride Re	10.	1-		· · · · · · · · · · · · · · · · · · ·
100 T		Brian C-Wa	llace p	W, 40.	DS KI14	oride Re	1, Dal	timo	e llu	121236
S	tate	31. Date filed (Month, Day, Year)	32. Registrar	s Signature	1		1		,	

			State of Maryland / Dep	eartment of Health and Nertificate of Death		2000	27015
ο,			Registrar  1. Decedent's Name (First, Middle, Last)	Timodio of Dodin	Reg. I		3. Time of Death
* *	Physici	_	Leonard Foley Gray, Sr.		November	12, 2005	06:55 A M
	/Medic Examin	- 6	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
			St. Mary's Nursing Center	Leonardtown		St. Mary	s
	Funeral Director		5. Social Security Number 6. Sex 15 M 2 F 7. Age (In yrs. last birthday 90 Yrs.	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth (Month, Day, Yea April 26, 1	ar) Cou	place (State or Foreign intry) 1and
	and		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or I	ocation			10d. Inside City Limits
	Maryl feho	ō	Maryland Saint Mary's Leonard	tourn			1 □Yes 2X No
	7 28a	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Cou	intry?
	h with		43033 Gray Way	20650		USA	
	deat	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. 13 Armed Forces?	. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Amer Black, White	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural", or Iteme 23e or 28e-f ehow early injury or other traumatic event, the Medical Examinar must be motified at ODGE.	þ	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: Whi	
2 2	72 hc	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of work	ing 16b	Kind of Business/I	ndustry
7	of hen.	d E	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)			
i T	Hygie Ther t		8 Heav	y Equipment Operat	e (First, Middle, Maid	Governme	ent
and	d be i	o Be	Leonard Mitchell Downs	Sarah El		on outraine)	
<u> </u>	Shoul nd Me mark	ဥ		ling Address (Street and Number or Rur		y or Town, State, Zi	p Code)
S	od 2 strau			33 Gray Way Leonard			
5	s 1 au f Hea ltem othe		20a. Method of Disposition 20b. Place of Disposition			Location - City or T	own, State
Ê	Page lent o nt: if ry or		1 LXBurial 2 Cremation 3 Chemoval from State	emorial Gardens Nov. 1	7. 2005 Leo	nardtown.	MD
Baltimore,	partition poorts poorts y inju		21. Signature of Funeral Service License	22. Name and Address of Facility			
<u>m</u>	8858		Wielrael & Landiner P.	attingley-Gardiner Fune O. Box 270, Leonardtow	n, MD 20650	Α.	
7			23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.				Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	ne Heant	Levi	ne	Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a onsequence of):				
	LAGITITIC		Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
	ted nsit	ni-	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury				
	al-tra	Examine	that initiated events resulting in death) Last c. Due to (or as a consequence of):				
8760,	eath certificate be executed attending physicien and for use as the burial-transit						
9		ledi					
Вох	th cer tendir r use	an/N	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3	□Ectopic pregnancy		23d. Date of deliv	•
П	that the death cer ed by the attendin detached for use	Physician/Medical	1 Yes 2 No	Other (specify)		Month	Day Year
P.O.	d by t	Phy	9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the	underhing as up a muse in Part I	22a Did tabasa	o use contribute to	the course of death?
rds,	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	Ď		Uaro	1 □ Yes		
Division of Vital Record	e law re has be je 2 sho	Completed			24a. Was an autopsy	24b. Were aut	opsy findings available ompletion of cause of
<u> </u>	ysicien: The la is certificate has director, page 2	Con			performed 1 ☐ Yes 2 ☐	? death?	
/ita	ilcien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?		h (Check only one)		
of	Physicien: r this certific ral director,	ပို	1   Yes 2   Hospital: 1   Inpatient 2   ER/Outpati		ome 5 Residence		ify)
Ë	ding f	on	27. Manner of Death 28a. Date of Injury 28b. Time Injury (Month, Day Year) 28b. Time Injury		28d. Describe how in	njury occurred	
isi	Attending r death. ector: After by the funer	icat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s		28f. Location (Street	and Number or Ru	ral Route Number
≧	after after Dire	Certification:	4 Homicide determined building, etc. (Specify)		City or Town, St	ate)	
	To the Hospitel or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	edical C	29a. Certifier (Check only (Check only 2   Medical Exeminer: On the basis of examination and/or	ath occurred at the time, date and place, investigation, in my opinion, death occur	and due to the cause red at the time, date	e(s) and manner as	stated. to the cause(s)
	To the h within 24 To the f	Med	one) and manner stated.  29b. Signature and file occurring	29c. License number		Date signed (Month	
	L W L		290. Signature and the order man	D6088	0		
	£ ~		The state of the s		· II	115/05	
	S		30. Name and address of Deceon who completed cause of death (Item 23a) (Typeran Rakhi Krishnan, M.D., 26840 Pt. Lookout Rd		. MD 20650		
#5 12.7	Str	ate	31. Date filed (Month, Ram Year) - 32. Recentrar's Signature	, 500 201, Heorial de Owi	., 20020		
1	Regist		NOV 1 5 2005	Breed			

		1 - For State of Maryland Registrar		artment of Health and M rtificate of Death		gie <u>Ne</u> 05	37916
Physic	ian	1. Decedent's Name (First, Middle, Last)  Catherine Georgia	_	Green	2. Date of Dea	Day Year 5 ZOOS	3. Time of Death 5 4 5 4 5 4
/Medi Exami		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death	7000.	4c. County of Dea	
		Northampton Manor		Frederick		Freder	
Funeral Director		5. Social Security Number  6. Sex  1 M 2 F 7. Age (In yrs. las.)  1 Vsuel Residence of Decedent	t birthday) Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birt	9. Bir 3, 1903	thplece (State or Foreign buntry) Md.
the Maryland 28a-f show	tor	10a. State 10b. County 10c. City, T					10d. Inside City Limits 1 ✓ Yes 2 ☐ No
h with the 23s or 28s	Funeral Director	10e. Street and Number 208 Phebus Ave.		10f. Zip Code 21701		10g. Citizen of What Co	
72 hours after death with the Maryla natural', or Items 23a or 28a-1 shov clical Examiner must be notified at	by Funera	11. Marital Status  1 Never Married 2 Married  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes. 2 No If Yes. Give Year or Dates:	1	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 1 No Specify:	ecify Yes or No Rican, etc.)	14. Race - Ame Black, Whit	e, etc.
ified within 72 hours after death with the Maryland Hygiene. Hygiene. Wher than "natural", or Items 23s or 28s-f show only, the Modical Examiner must be multiled at	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	(Give	dent's Usual Occupation kind of work done during most of work DO NOT use retired)  1 C S £ 1 C	ing	16b. Kind of Business Restau	,
ife, Mal ylail of LLC 12-13-70 s 1 and 2 should be filed within 72 hr f Health and Mental Hygiene. Item 27 is marked other than "natu other treumatic event, the Madical	To Be Co	17. Father's Name (First, Middle, Last) Jessie Brown		18. Mother's Nam	Brou		
and 2 sho and 2 sho ealth and ? n 27 is me		19a. Informant's Name/Relationship (Type, Print) Renee Diggs (grandaushtu)	19b. Mailin	ng Address (Street and Number or Rur ) Key Parkway 20	Z FYC	er, City or Town, State Levick M	Zip Code) 14 21702
) 0 0 <del></del>		COST	hav	en Mem. Gar, No			rich Md.
permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service Poensee  Sury L. Kollein	6	2. Name and Address of Facility, Fr ary L. Forms Fr O West South	ineval St Fr	Home ederick,	md. 21701
Physician		23a. Part 1. Enter the disease, or complications that caused the death. shock, or hear failure. List only one cause on each line.  Immediate Cause (Final			or respiratory as	rrest,	Approximate Interval Between Onset and Death
/Medical Examiner		Due to (or as a consequent		HONRY FAILURE			NONTHS
executed an and rial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	nce of):				
of ou, sate be executed hysician and the burial-transit	dicai Exa	resulting in death) Last  Due to (or as a consequent of the conseq	nce of):				
A DO artificating physical phy	l o	IF FEMALE:					
wrequires that the death certificate be very great signed by the attending physicial should be detached for use as the but	Physician/M	23b. Was decedent pregnant in the past 12 months?  1  Yes 2  No 9  Unknown	eath 3[	□Ectopic pregnancy □ Other (specify)		23d. Date of de Month	livery Day Year
ecords, F.O. law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions contributing to death but not resulting		Inderlying cause given in Part I.		obacco use contribute t	o the cause of death?
lecorus, law requires l has been signe	Completed				24a. Was		utopsy findings available completion of cause of
VICAL MEC reiclan: The law s certificate has t lirector, page 2 s		25. Was case referred to medical		CC Plant of Date	1 Tes	2 <del>€</del> No 1 □ Yes	2 □ No
OT VITA Physiclan: this certific ral director,	o Be	examiner?	P/Outpatie	nt 3☐ DOA Other: 4 Nursing Ho		dence 6 □Other (Spe	ocify)
VISION OF VITA  Attending Physician: or death. rector: After this certific by the funeral director,	ation: T	27. Manner of Death  1 Anatural 5 Pending 2 Accident investigation  28a. Date of Injury (Month, Day Year) 2 2	8b. Time o Injury			how injury occurred	
DIVIS el or Atte s after de il Directo	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At hom building, etc. (Specify)	e, farm, st	reet, factory, office	28f. Location (; City or Tox	Street and Number or R wn, State)	ural Route Number,
DIVISION To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical C	29a. Certifier (Check only one)  155 Certifying Physician: To the best of my knowl and manner stated.					
To th withir To th comp	×	29b. Signature and title of certifier		29c. License number		29d. Date signed (Mon	
5			10-1/7	732171		11/8/	03
9		30. Name and address of person who completed cause of death (Item 2		Print) WALLERSULLE	mo 21	743	
S Regis	tate trar	31. Date filed (Month, Day, Year)  NOV 1 0 2005		Sparke			

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** November 2005 2:50am Ellen Galen /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wilson Health Care Center Gaithersburg Montgomery If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕱 F Director 76 1929 Maine 004-26-4228 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits rthan "natural", or Items 23a or 28a-f show the Medical Examitive must be codified at 1 ☐ Yes 2 X No Maryland | Montgomery Brookeville Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18556 Queen Elizabeth Drive 20833 Funerai United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖫 No Specify: Specify: þ 3X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home other traumatic avent, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Is marked of permit. Pages 1 and 2 should be Department of Health and Ment Important: If item 27 Is marked John D. Haley Esther M. Knight 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 161, Great Falls, VA 22066 Evan H. Galen (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State injury or b \* 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 11/7/2005 Alexandria, Virginia 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Drive Gaithersburg, MD 20877 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23 r. Part 1. Err er the dise the complications that carried the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on york line. Immediate Cause (Final disease or condition resulting in death) metastaticarcinomatolicaen **Physician** /Medical **Examiner** nal cell curcinoma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. attending physician Completed by Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) 4☐Pregnant at time of death 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 25. Was case referred to medical examiner? chime dese 2 🗆 No 1 Tyes 2 No Hospital or Attending Physician: Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 Yes 2 No Other: 2 4 Nursing Home 5 Residence 6 Other (Specify) 27. Many r of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending To the rospinal within 24 hours after death.

To the Funeral Director: Aft investigation 1 Tes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) (Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Nagentier 6,2005 N. Roberton 1004-115 1 RUSSELL AUENVILE 30. Name and address of person who completed cause of death (Item 23a) Type, Print H. ROBERTSIRSCHBALLI, MLD GAITHERSBURG, NULL Year) 31. Date filed (Month 32. Registrar's Signature State Registrar

			1 - State of M	laryland / Depa		lealth and M	lental Hygie	-	37918
	Physici /Medio		1. Decedent's Name (First, Middle, Last)  Richard Garnitz				2. Date of Death Month October	30°, 2005°	3. Time of Death 8:15 A. M
	Examir		4a. Facility Name (If not institution, give street and number Suburban Hospital	)	4b. City, Town, o	or Location of Death		4c. County of Death	
	Funeral Director		315-09-9671 X X 2 F	ge (In yrs. last birthday) 84 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day, Y Feb. 11,	9. Bint 1921 IG	nplace (State or Foreign Linois
	Maryland f show	o	Usual Residence of Decedent  10a. State 10b. County  Maryland Montgomery	10c. City, Town or Lo Silver Sp					10d. Inside City Limits T☐ Yes 2 ☐ No
	with the	Direct	10e. Street and Number	Ant 530	10f. Zip Code	906	10g	. Citizen of What Cou	untry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: if Item 27 is marked other then "natural", or Items 23s or 28s-f show eny injury or other traumatic event, the Madical Examinar motal be notified at once.	by Funeral Director	3310 N. Leisure World Blvd  11. Marital Status  1 Never Married 2 Marned 3 Widowed 4 Divorced  12. Was Deceden Armed Forces 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	t Ever in U.S. 13. Y ? INO Army		Hispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
1215-0	vithin 72 ho ne. hen "natur e Mudical	Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or	(Give life. I	dent's Usual Occup kind of work done DO NOT use retire tor of Of	during most of worki fice of	ng	b. Kind of Business/l	
Baltimore. Marvland 21215-0036	d be filed w ental Hygier ced other ti	Be	17. Father's Name (First, Middle, Last)	Inte	ernationa	18. Mother's Name	ng (First, Middle, Ma. Diamond		overnment
Mary	nd 2 shoul aith and Me 27 Is mark	To	Robert Garnitz  19a. Informant's Name/Relationship (Type, Print)  Sydelle M. Garnitz - Wife	19b. Mailir	ng Address (Street		l Route Number, C	City or Town, State 7	ver Spring 20906
more.	Pages 1 and of Height: If I tem		20a. Method of Disposition  1 Burial 2 Command 3 Removal from State 4 Donation 5 Other (Specify)	20b. Place of Dispo cemetery, cren	osition (Name of matory or other pla		ate 20	c. Location - City or T	
Balti	permit. Departr Imports eny inju		21. Signature of Funeral Service Licensee  Oorold					Chapels, Lle, Maryl	
	Physician /Medical		23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each immediate Cause (Final disease or condition resulting in death).	ed the death. Do not enti- line. nage Transfo	ter the mode of dyir	ng, such as cardiac o	r respiratory arrest	,	Approximate Interval Between Onset and Death Days
	Examiner	ler	Sequentially list conditions b. Ischem.	s a consequence of):  ic Stroke s a consequence of):					Days
8760.	rate be executed hysician and the burial-transit	ilcal Examiner	triat iritiated events C.	Fibrillations a consequence of:	on				Years
10/36/05 P.O. Box 68	Physician: The law requires that the death certificat this certificate has been signed by the attending phy ral director, page 2 should be detached for use as th	by Physician/Med		2 Fetal death 3	Ectopic pregnancy Other (specify)	1		23d. Date of deliv	very Day Year
	w requires that been signed b should be deta	ed by PI	Part II. Other significant conditions contributing to death  Metastatic Prostate Can		nderlying cause giv	ren in Part I.	23e. Did tobac	co use contribute to	the cause of death?
RICHARD	The law re ate has be page 2 sho	Completed					24a. Was an autopsy performed	24b. Were autoprior to condeath?	opsy findings available ompletion of cause of
RIC! Vita	Physician: The this certificate had director, page	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 No Hospital: ☐ Inpat	ient 2 ER/Outpatien	nt 3 DOA Oth	26. Place of Death		e 6 □Other (Speci	(v)
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	atlon:	27 Manner of Death 1 M Natural 5 Pending 2 Accident investigation 28a. Date of Inj (Month, Di		Wor		28d. Describe how	<del></del>	77
GARNITZ OSICA Division	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer.	Certification:	4 Homicide building, e	njury - At home, farm, stre tc. <i>(Specify)</i>			City or Town, S		
GA	the Hospital hin 24 hours a the Funeral I nplataly filled	Medicai	29a. Certifier (Check only one)  1 Certifying Physician: To the bes 2 Medical Examiner: On the basis and manner s	oi examination and/or inv	h occurred at the tir vestigation, in my o	ne, date and place, a pinion, death occurre	and due to the caus ad at the time, date	e(s) and manner as s and place, and due t	stated. to the cause(s)
	T with con	Ν	29b. Signature and titlerof certified	VEURULOS) BULBAN HO	SPNAS Licens	P8376	) 1 L	Date signed (Month, $\frac{3}{2}$ )	Day, Year)
	3		30. Name and address of person who completed cause of Alison Baird, M. D. 10 (	death (Item 23a) (Type, Center Drive		-N-258, B	ethesda,	Maryland	20892
	Sta Registr			rar's Signature	sille!				

John Higgins 05-07407 crn

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item/9, perfn. G849, 11/29/05 TT

			For State Registrar	State of Ma		ertificate of L		Re	g. No.	05	37919
	Physici /Medic		1. Decedent's Name (First, Middle, Last) $Jo$	hn Higg	ins			2. Date of Deat Month Novembe	Day	Year 2005	3. Time of Death
	Examir		4a. Facility Name (If not institution, give state 110 S. Eutaw Stree	t, Room 4		Balti	More II Under 24 Hrs.		4c. Count	y of Death	
	Funeral Director		5. Social Security Number 027–28–4008 6. Septime 118	IN OUR	(In yrs. last birthday 58 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Mar. 26	,1937 .	9. Birthp Coun Peab	place (State or Foreign http)  MA  MA
	Aaryland I show	or	10a. State 10b. County		10c. City, Town or L Locust Gr					1	0d. Inside City Limits  1 Yes 2 □ No
	death with the Maryland ms 23a or 28a-f show	I Director	VA Orange  10e. Street and Number  120 Skyline Drive			10f. Zip Code 22509	)		0g. Citizen of	What Coun	
980	ours after	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Year or Dates:	<sup>ve</sup> 1959 to 13.	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	spanic Origin? (Spen, Mexican, Puerto I	cify Yes or No- Rican, etc.)	Bla	ce - Americ ick, White. fy: White	etc.
Maryland 21215-0036	72 hc	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+ 5+	-)	edent's Usual Occupa e kind of work done o DO NOT use retired er Military—		ng	16b. Kind of E US Gove		*
/land	12 should be filed within " h and Mental Hygiene. 7 is marked other than " fraumatic event, the Mass	To Be C	17. Father's Name (First, Middle, Last) Michael Francis H	iggins			18. Mother's Name Mary Lou			me)	
, Man	and 2 sho saith and I n 27 is ma		19a. Informant's Name/Relationship (Ty Nancy Flynn Higgin		120	ling Address <i>(Street a</i> Skyline Dr	rive, Locu	I Route Number, 1St Grov	e, VA	, State, Zip 22509	Code)
Baltimore,	permit. Pages 1 and 2 Depertment of Health a important: If item 27 ti any injury or other tra ance.		20a. Method of Disposition 12 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State	Arlingto	osition (Name of ematory or other placents)  Nat'l. (	Cem. 12-3	30-05 A	20c. Location $rlingt$	on, V.	A
Balt	permit. Depertr importu any inju		21. Stonature of Euneral Service Pensi	il_		22. Name and Addres					C.
	Physician /Medical Examiner	ılner	23a. Planti. Enter the disease, or complishock, or heart lailure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury)	Arterioso  Due to (or as a	э.	Cardiovasc			sst,		Approximate Interval Between Onset and Death
68760,	tificate be executed g physicien and as the burial-transit	edical Examiner	that initiated events 'resulting in death) Last	Due to (or as a	consequence of):						
P.O. Box 6	that the death certificated by the attending of detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome o 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)				ate of delive	ory Day Year
	w requires that been signed t should be deta	ed by P	Parkinson's Disea		_		en in Part I.				ne cause of death? ably 4 XUnknown
Il Reco	The law ate has b page 2 st	Completed by						24a. Was ar autops perform 1 \( \text{Yes} \) 2	ned?		psy lindings available inpletion of cause of
Vita	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	lospital:		100	26. Place of Death		*		
Division of Vital Records,	ling Phys I. After this luneral dir	atlon: To	1 X Yes 2 No   27. Manner of Death  1 Vatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	t 2 ER/Outpatie 28b. Time a 1 Injury	of 28c. Injury Work	4 U Nursing Hon	ne 5 Reside 28d. Describe ho			at scene
Divis	tal or Atte s after de ni Directo ed in by th	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur building, etc.	y - At home, larm, s (Specify)	treet, lactory, office	2	28l. Location (Str City or Town	reet and Numi , State)	ber or Rura	l Route Number.
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the 1	edical	29a. Certifier (Cneck only one)  1 Certifying Physical Examination (Cneck only one)	sician: To the best of her: On the basis of and manner stat	examination and/or is	ith occurred at the tim nvestigation, in my op	e, date and place, a pinion, death occurre	and due to the ca ad at the time, da	use(s) and m ite and place,	anner as stand due to	ated. the cause(s)
	To the within 2 To the complet	Ž	29b. Signature and title of certifier		4/	29c. License	number	25	d. Date signe	ed (Month, L	Day, Year)
	,		30. Name and address of person who co	mpleted cause of de	//	. Print)	.M.E.		Novembe		
1			CAROL HAT	LAWI	1- C'	Penn Str	eet, Balt	imore, N	arylar)	nd 212	.01
*\$	Sta Registi		31. Date liled (Month, Day, Year) NOV 0 9 2005	32. Registra	rs Signature	les .					

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Medical Examiner   4a Facility Name (In an institution, pine street and number)   4b. City, Town, or Location of Death   4c. County of the Clen Burnie   4c.
Second Process   Seco
S. Social Security Number   6.5 sex   1 m Right   7.9 sex   1 m Right   10c. City, Town or Location   10c. City, Town or Loc
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The father's Name (First, Middle, Last)   The father's Name (First, Middle, Last)
The father's Name (First, Middle, Last)   The father's Name (First, Middle, Last)
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The father's Name (First, Middle, Last)   The father's Name (First, Middle, Last)
The father's Name (First, Middle, Last)   The father's Name (First, Middle, Last)
Physician / Medical Examiner  Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):
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FFEMALE:   23c. If yes, outcome of pregnancy   23d. Date of out of the past 12 months?   1
FFEMALE:   23c. If yes, outcome of pregnancy   23d. Date of out of the past 12 months?   1
O et at Age of the significant conditions contributing to death but not resulting in the underlying course gives in Rest I.    Age   I   Other significant conditions contributing to death but not resulting in the underlying course gives in Rest I.
O et at Age of the significant conditions contributing to death but not resulting in the underlying course gives in Rest I.    Age   I   Other significant conditions contributing to death but not resulting in the underlying course gives in Rest I.
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  1   Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  1   Yes 2   No 3
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of the same of the
24a. Was an autopsy and prior in the control of the
25. Was case referred to medical examiner?  1   Yes   2   2   No   1   Yes   2   No   1   Yes   2   Xes   Xe
To the sidence of the contract
Solution of the second of the
. 2 Parity 2 Accident investigation M 1 Yes 2 No
. S = 0 0 E
1 Stratural 1 Stratural 2 Accident 3 Suicide 4 Homicide 4 Homicide 4 Homicide 5 Pending investigation 6 Could not be determined 5 Pending investigation 1 Suicide 4 Homicide 4 Homicide 4 Homicide 5 Pending investigation 1 Pending investigation 2 See. Place of Injury At home, farm, street, factory, office 286. Describe now injury occurred 1 Injury M 1 Types 2 No 286. Describe now injury occurred 286. Describe now
27. Manner of Death  28a. Date of Injury  (Month, Day Year)  28b. Time of Injury M  1 Yes 2 No  28c. Injury at Work?  1 Yes 2 No  28b. Location (Street and Number or City or Town, State)
288. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  286. Location (Street and Number or City or Town, State)  287. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.
28e. Place of Injury - At home, farm, street, factory, office  10
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner (Check only one)  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.
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29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner (check only one)  29b. Signature and title of certifier  29c. License number  29d. Date signed (Mo. 2)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner (Check only one)  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.  29b. Signature and title of certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.  29c. License number  29d. Date signed (Mo

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 2005 11:40A M November Calvin Ha11 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S 7770 MUNCY ROAD LANDOVER If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 25 9. Birthplace (State or Foreign **Funeral** 1⊠M 2□ F 79 Yrs Director 432-30-8994 ARKAŃSAS DECEMBER Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. Count 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examinar must be nutified at Director PRINCE GEORGE'S LANDOVER 1X Yes 2 ☐ No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 23a 7770 MUNCY ROAD U.S.A. Completed by Funeral 20785 Pages 1 and 2 should be filed within 72 hours after death inent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or Items 23 12. Was Decedent Ever in U.S. Armed Forces?

¹Xi Yes 2□No Arm
If Yes, Give
Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2X Married Armv Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify BLACK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 2yrs DEPT OF STATE GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be WILLIE T. HALL ERMA TAYLOR 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ELEANOR HALL/WIFE 7770 MUNCY ROAD LANDOVER, MARYLAND 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place) 5 1 Burial 2 □ Cremation 3 □ Removal from State Department of Important: If any injury or once. 11/12/2005 AMHERST, VIRGINIA FAMILY PLOT <sup>1</sup> 4 □ Donation 5 □ Other (Specify) 21. Signature done at Service Lidense 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** MALIGNANT PLURAL EFFUSION resulting in death) /Medical Due to (or as a consequence of): Examiner SARCOMA Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit PROSTAGE CANCER Due to (or as a consequence of): Box 68760, physician Physician/Medicai use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? Year Month Day 4 ☐ Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown 5 been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 287 No 1 Yes 2€□ No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) axaminar? Other: Certification: To 1 ☐ Yes 2 🔀 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Nesidence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 Yes 2 No death. 2 Accident after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a hours 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of gertifie 30. Name and address of person who completed cause of death (Item 26a) (Type, Print) Kimberly Bolling M.D. 4000 MITCHELLVILLE ROAD A-204 BOWIE, MARYLAND 20716 31. Date filed (Month, Day, Year) . Registrar's Signature State NOV 0 8 2005

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Registrar

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Physician /Medical Examiner  Sequentially list days, leading to the attending by the attending properties as the primary resulting in deal disease or connections and disease or connec	se (Final dition th) t conditions, o immediate nderlying	aDue to	to (or as a orns	Canc	ter the mode of dy	ring, such as	cardiac or	respiratory an	rest.	Interval Between Onset and Death
Examiner  Sequentially list if any, leading to cause. Enter U. Gause (Disease that initiated ever that initiated ever the detached tor use as the prival transit that initiated ever that initiated ever the detached to the d	t conditions, o immediate nderlying e or injury	b		sequence of):						
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bed bed bed bed bed	12 months? 2 ☐ No	1 Live	outcome of prede birth 2 Fignant at time of known	etal death 3	□Ectopic pregnand □ Other (specify)	су			23d. Date Mont	o of delivery th Day Year
law reas becases becases becases becases becases becases because and because b	gnificant conditi	ions contributing to	death but not	resulting in the u	inderlying cause gi	iven in Part I				bute to the cause of death? 3 ☐ Probably 4 ☐Unknow
The page								24a. Was a autop perfor 1 Yes	med?   de	/ere autopsy findings available fior to completion of cause of eath?  ☐ Yes 2☐ No
The property of the property	eath 5 🗌 Pendir	Hospital: 1 [	Inpatient 2 te of Injury onth, Day Year	2 ER/Outpatie 28b. Time o	f 28c. Inju	then 4 🗆 Nu	ursing Hom	(Check only or ne Resid 8d. Describe h	SON	n's residance r (Specify) ad
Within 24 hours after death.  To the Hospitel or Attending Paymer at Jack the Funeral Director: After completely filled in by the funeral Completely filled in by the funeral Completely filled in by the funeral Complete (Check only one)  Medical Certification:  Say Natural Complete (Check only one)  3	6 ☐ Could	I not be 28e. Plac	ce of Injury - A Iding, etc. (Spe	At home, farm, st ecify)	reet, factory, office			8f. Location (S City or Tow		or or Rural Route Number,
he Hospit he Hospit he Funers and Check only one)	1 Certifyii 2 Medical	ng Physicien: To the I Examiner: On the and ma	the best of my be basis of exame anner stated.	knowledge, deat nination and/or in	h occurred at the to evestigation, in my	time, date an opinion, dea	nd place, ar	nd due to the d d at the time, d	ause(s) and man date and place, ar	nner as stated. nd due to the cause(s)
29b. Signature	and title of certifie	Il A	Pet 1		29c. Licen	nse number	(01			(Month, Day, Year)
		- 000	use of death (I	Item 23a) (Type,	Print)	7.10	VI		NOV. 1,2	.003
ARAT	ddress of person	n who completed cal								

		State of Man		partment of H			•	
	•	For State Registrar	•	ertificate of l		, ,	. Not? A A E	07000
Physicia	an	Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3) Tinle of Death
/Medic		Helene B. Horvat				November	7,2005	
Examin	er	ta. Facility Name (If not institution, give street and number)		Germantown	Location of Death		4c. County of Deat Montgome	
Funeral		19916 Lake Park Dr. 5. Social Security Number 6. Sex 7. Age (i	In yrs. last birthd	ay) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Birt	hplace (State or Foreign
Director		492-20-7960 1□M 2√F	83 Yrs	Months Days	Hours Min.	(Month, Day, Y 9/16/22	ear) Co	ssouri
pus *		Usual Residence of Decedent  10a. State 10b. County 1	Oc. City, Town or	Location				10d. Inside City Limits
Manyle f sho	20	MD Montgomery						1 Styles 2 □ No
r 28e-	Director	100 Street and Number	Germant	OWD 10f. Zip Code		10g	. Citizen of What Co	untry?
th with	alD	19916 Lake Park Dr.		20874			USA	
er dea	Funeral	11. Marital Status 12. Was Decedent Eve Armed Forces?		<ol> <li>Was Decedent of Hi If Yes, specify Cuba</li> </ol>	ispanic Origin? (Spe in, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
rs afte	by F	1 Never Married 2 Married 1 Nes 2 No No Nes Note 1 No Nes Nes Nes Nes Nes Nes Nes Nes Nes Nes	WIT T	1 ☐ Yes 2 🔀 No	Specify:		Specify:	
2 hou	ted I	15. Decedent's Education	16a. De	cedent's Usual Occupa		16	b. Kind of Business/	
thin 7	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	- life	ive kind of work done one of the contract of t	during most of workir ()			
led wi		12 2	Exec	utive Secr	-		Governme	ent
d be findal H and off	Be	17. Father's Name (First, Middle, Last)  George Horvat			18. Mother's Name Anastas:		iden Surname)	
should nd Me mark imatic	은	19a. Informant's Name/Relationship (Type, Print)	19b. M	ailing Address (Street a			City or Town. State. 2	Zip Code)
alth a		Cecil Day/Nephew		6 Lake Par			MD 20874	.,
es 1 a of He fitam r othe			20b. Place of Di	sposition (Name of crematory or other place	D.		c. Location - City or	Town, State
Pag tment tant: I		4 Donation 5 Other (Specify)	Cremati	ion Center	Nov.	2005 C	hantilly,	Virginia
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "netural", or items 23e or 28e-f show any Injury or other treumatic event, If a Medical Exertifier in a final be notified at once.		21. Signature of Funeral Service Ligensee	and CF	22. Name and Address Mirphy Fl	ss of Facility [I 4510 W1]	lson Blvd	J. Arl., V	A 22203
SUE	2024	23a. Part1. Enter the disease, or com. in tions that caused the shock, or heart failure. List only one cause on each line.	e death. Do not	enter the mode of dyin	g, such as cardiac o	r respiratory arrest	,	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition resulting in death)  Lymphoma a	of Brain	n				Onset and Death
/Medical Examiner		Due to (or as a c	consequence of):					
	er	Sequentially list conditions D.	consequence of):					
outed id ansit	Examiner	cause. Enter Underlying Cause (Disease of Lifer) that initiated events  c. Dementia						
te be executed ysician and ne burial-transit		resulting in death) Last Due to (or as a c	consequence of):					
2 > 2	dicai	d						
The law requires that the death certificate tate has been signed by the attending physicage 2 should be detached for use as the b	Physician/Med	IF FEMALE: 23c. If yes, outcome of	pregnancy				23d. Date of del	ivery
death e atte	iciar	in the past 12 months?	_	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			Month	Day Year
at the by the	hys	9 Unknown						
w requires that the d been signed by the should be detached	by	Part II. Other significant conditions contributing to death but r	not resulting in th	e underlying cause give	en in Part I.			the cause of death?
requi	eted					1 L Yes	2 □ No 3 □ Pr	obably 4 🕅 Unknown
The law cate has t page 2 s	Completed					24a. Was an autopsy performe	prior to	topsy findings available completion of cause of
	e Co	25. Was case referred to medical			Of Blace of Dooth	1 □ Yes 2 €	No 1 ☐ Yes	2 No
ysicia is cert direct	0 8	examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient	2 ☐ ER/Outpa	itient 3 DOA Othe	26. Place of Death		e 6 Other (Spe	cify)
ding Phys h. After this funeral dii	on: T	27. Manner of Death 1 Natural 5 Pending (Month, Day Y	(ear) 28b. Time Injur			8d. Describe how		,
tandi leath. tor: A the fu	catl	2 Accident investigation		M 1 🗆 '	Yes 2□No			
l or At after c Direc	Certification:	4 Homicide determined 28e. Place of Injury building, etc. (	r - At home, farm, (Specify)	street, factory, office	2	8t. Location (Stree City or Town, 3	et and Number or Ru State)	iral Route Number,
To the Hospitel or Attending Physicien: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	Medicai C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of received the desired physician on the basis of endingent physician and manner states	xamination and/o	eath occurred at the time investigation, in my of	ne, date and place, a pinion, death occurre	and due to the caused at the time, date	se(s) and manner as	stated. to the cause(s)
ro the	Me	29b. Signature and title of certifier		29c. License	e number	29d	. Date signed (Monti	h. Day, Year)
		Dionnes V.	Purph	D004	47330		Nov. 8,20	005
(10)		30. Name and address of person who completed cause of deat	th (Item 2 a) (Ty	pe, Print)				
Sta	ate.	Thomas V. Joseph M.D., 50 W 31. Date filed (Month, Day, Year) . Registrar's			,#2∪/, Koc	ckville,	ıa.	
Registr		31. Date filed (Month, Day, Year)  NOV 1 0 2005	1 Ap	and in				

Registrar DHMH 17 Rev 1/2001

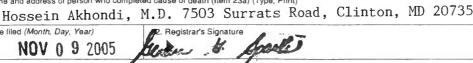
Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

				State of Man						•	•			
		•	For State Registrar				ficate of			g. No 2 0 0 5	37924			
*	Physici	an	1. Decedent's Name (First, Middle, La	·					2. Date of Death Month	Day Yea				
	/Medic	cal	Holly Bertson .  4a. Facility Name (If not institution, gir			- 4	h City Town o	or Location of Death	NOVEMBE	4c. County of De				
	Examin	er	Saint Joseph		Cent	1	b. City, Town, C	Tows			ltimore			
	Funeral				n yrs. last	N	f Under 1 Year lonths Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. E	Birthplace (State or Foreign Country)			
4,5	Director		235-28-2838 Usual Residence of Decedent	1XM 2□F	81	Yrs.			January 24		WV			
	yland		10a. State 10b. County	10	c. City, T	own or Locat	ion				10d. Inside City Limits			
	8a-fel	ctor	MD Washing	ton	Har	ncock					1 ☐ Yes 2 💢 No			
	be filed within 72 hours after death with the Maryland that Hygiene. Id other then "naturel", or items 23a or 28a-f ehow event, ite Medical Evaluar meters the Lodified at	Funeral Director	10e. Street and Number	Didas Dasi			10f. Zip Code	750	10	)g. Citizen of What USA	Country?			
	items 23	eral	14260 Tollgate  11. Marital Status	12. Was Decedent Eve	r in U.S.	13. Was		Hispanic Origin? (S an, Mexican, Puert	pecify Yes or No-	14. Race - Ai	merican Indian,			
9	or ite		1 Never Married 2 Married	Armed Forces? 1 X Yes 2 □ No If Yes, Give			es, specify Cub  Yes 2∭X No	an, Mexican, Puert Specify:	o Rican, etc.)	Black, W Specify:	hite, etc.			
21215-0036	hours lurel',	d by	3 ¥ Widowed 4 □ Divorced Year or Dates:								White			
-15	nin 72 n "nai	Completed	15. Decedent's E (Specify only highest gi		(Give kını	t's Usual Occup d of work done NOT use retire	during most of wor	king	6b. Kind of Busines	ss/industry				
212	filed withi Hygiene. other then	E O	8	College (1-4or 5+)		Carpen	ter	,		Construct	ion			
and	should be filed withir nd Mental Hygiene. marked other then imatic event, II.e.M.	Be	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Mid							laiden Sumame)				
Maryland	should be and Mental is marked o	To	James Edward Jari 19a. Informant's Name/Relationship			19b Mailing A	Address (Street		a Naylor	City or Town State	Zin Code)			
<u>⊠</u>	and 2 s salth an n 27 ie ier trau		Junius G. Jarret					Road Han						
Baltimore,	- I = 5		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 (		20b. Place ceme		on (Name of ony or other pla		-	0c. Location - City				
ij	permit. Pages Department of I Importent: If its eny injury or o	Ш	4 □ Donation 5 □ Other (Spec	ity)	race			L PK 11/1	-	ew Castle				
Bal	Departr Departr Imports eny in		21. Signature of Funeral Service Lice	general services			ame and Addre			Main Str				
8			23a, Part1. Enter the disease, or cor	nolications that caused the	death. [						21750-0368  Approximate Interval Between			
	Physician		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition								Onset and Death			
33.	/Medical Examiner		resulting in death)	Due to (or as a co	5 MINS.									
ь	Lxammer	-	Sequentially list conditions.	b. ARRHYTHMIA  Due to (o: as a consequence of):										
$\sqrt{}$	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	TE VELE		DISEASE								
,092	e exec ian an irial-tr		resulting in death) Last	Due to (or as a co			SSEL I	SCHEMIC	LEART	CO-METIME				
6876	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dlcal		d.						·	- unversity			
ox 6	certifi nding use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p						23d. Date of d	delivery			
Ω.	death e atter	iciar	in the past 12 months?  4 Pregnant at time of death  5 Other (specify)							Month	nth Day Year			
P.0	that the ded by the destached	Phys	9 Unknown 9 Unknown											
	signed be det		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  ACUTE ON CHRONIC RENAL FAILURE							d tobacco use contribute to the cause of death?  Yes 2 \[ No 3 \[ \] Probably 4 \[ \]Unknown				
Records,	w requir been si should	lete	DIABETES MELLITU		I D				24a. Was an					
Re	sician: The law certificate has t irector, page 2 s	Completed by	HYPERTENSION							prior t ed? death No 1 □ Y				
/ital	iysician: The Is certificate hadirector, page	Bec	25. Was case referred to medical examiner?						1 Yes 2	0,	7			
of Vital	Phy ald	ုင	1 Yes 2 No	Hospital: 1 Inpatient		Outpatient b. Time of	3 DOA		nce 6 □Other (S <sub>i</sub> w injury occurred	pecify)				
on	ding th: : After s funer	Certification;	1 Natural 5 Pending 2 Accident investigate	28a. Date of Injury (Month, Day Y	ear)	Injury	28c. Injui Wo	rk? ]Yes 2 □ No	28d. Describe no	w injury occurred				
Division	Atter Br dea rector by the	tifica	3 ☐ Suicide 6 ☐ Could not determine		- At home	, farm, street	, factory, office		28f. Location (Str City or Town	eet and Number or	Rural Route Number,			
ō	Hospital or Attending 24 hours after death. Funeret Director: After itely filled in by the fune													
	To the Hospital or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Medical	29a. Certifier 1 Certifying P (Check only one) 1 Medical Exe	hysician: To the best of no eminer: On the basis of ex and manner stated	amination	dge, death oo and/or inves	curred at the til tigation, in my o	me, date and place opinion, death occu	, and due to the ca rred at the time, da	use(s) and manner te and place, and d	as stated. lue to the cause(s)			
	To the within 2 To the comple	Me	29b. Signature and title oncertifier				29c. Licens	se number	29	d. Date signed (Mo				
				seul			D Ø	057904		11-15-0	20			
	5		30. Name and address of person who	completed cause of deat	h (Item 23	Ba) (Type, Pri								
C <sub>p</sub>	Sta	ate	31. Date filed (Month, Day, Year)	32. gistrar's	1 () Signature	SLERI		TOWSON,	MARYLA	ND 21204	+			
- X	Regist		NOV 2 3	2005 Street	1	400	W.							

		State of Maryland / Departm		•	•				
		, roi	eate of Death	Reg. I	0000	27025			
1,48	Ok.	Decedent's Name (First, Middle, Last)		Date of Death	<u> </u>	3. Time of Death			
Physici /Media		VICTORIA JAMES		Month 15	Say OS	00:45 AM			
Examir			City, Town, or Location of Death		4c. County of Death	1			
<b>s</b>	* .	00:000	nder 1 Year   If Under 24 Hrs.   8	Data of Righ		Hlegany			
Funeral Director		5. Social Security Number 159 14 2371  Usual Residence of Decedent  6. Sex 1 M 2 X F 88 Yrs.  7. Age (In yrs. last birthday) If Ur Mont		Date of Birth (Month, Day, Yea CC 11 191	ar) Coi	nplace (State or Foreign untry) NSYLVANIA			
/land		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits			
Many e-f eh	tor	MARYLAND ALLEGANY FROSTBURG				1X Yes 2 □ No			
ith the	Directo		. Zip Code	10g.	Citizen of What Co	untry?			
ath w	ler	102 MT. PLEASANT STREET	21532		J.S.				
ter de Items	Funeral	11. Marital Status  1 □ Never Married 2 □ Married  12. Was Decedent Ever in U.S.  Armed Forces?  1 □ Yes 2 ☒ No	ecedent of Hispanic Origin? (Specify specify Cuban, Mexican, Puerto Ric	y Yes or No- an, etc.)	14. Race - Amer Black, White				
urs af	b	If Yes, Give 1 ☐ Ye  3 ☑ Widowed 4 ☐ Divorced Year or Dates:	s 2🕅 No Specify:		Specify:	WHITE			
ite, INICITY ICITION AT A TONE STORY STATE OF A THE MANY AND STAND 2 Should be filled within 72 hours after death with the Manyland of Health and Mental Hygiene. Item 27 is marked other then "natural, or items 23a or 28e-1 ehow other traumatic event, the Madical Examinar must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind or	Usual Occupation f work done during most of working	16b.	Kind of Business/l	ndustry			
Aithin ne.	mple	Elementary/Secondary (0-12) College (1-4or 5+)	T use retired)		OFD: 11017	-			
iled w therti		12 HOMEM	IAKER  18. Mother's Name (F	irst Middle Maid	OWN HOM	E			
d be d be d be d be d be d be d be d be	To Be	JOSEPH PERDEUS	CATHERIN						
should be nd Mental marked o	F	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addi	ress (Street and Number or Rural R	oute Number, Cit	y or Town, State, Z	ip Code)			
and 2 and 2 ealth a n 27 is		JOHN JAMES / SON 98 HERITA	AGE WAY, NE, APT	108, LE	ESBURG, V	'A 20176			
of He		20a. Method of Disposition  20b. Place of Disposition (cemetery, crematory)	(Name of Date or other place)	20c.	Location - City or 1				
Pages ment of lant: If its		4 Donation 5 Other (Specify)	MORIAL PAKR 11/1		OSTBURG,				
Dalling Permit. Pages Department of Important: If it eny injury or o			e and Address of Facility  SFUNERAL HOME,		W. MAIN	ST MD 21532			
40200		23a. Part 1. Enter the disease, or complications that caused the death, Do not enter the			Oblbuke,	Approximate			
		shock, or heart failure. List only one cause on each ine.	1 10	spiratory arrest,		Interval Between Onset and Death			
Physician /Medical		disease or condition resulting in death)  Due to (or as a consequence of):				3days			
Examiner		Sequentially list conditions							
D H	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury							
be executed icien and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C.  Due to (or as a consequence of):							
te be executed ysicien and le burial-transit	alE								
oo / ifficate g phy: as the	edlo	0.							
ath cert attendin for use	M/us	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopi	ic pregnancy		23d. Date of delivery  Month Day Year				
e deal	Physician/Medi	in the past 12 months?  1							
that the		Part II. Other significant conditions contributing to death but not resulting in the underlying	ng cause given in Part I	23e. Did tobacc	o use contribute to	the cause of death?			
Lisigne d be	d by	Commony antiny discover	g daddo grott itt at ti	1 ☐ Yes 27No 3 ☐ Pr					
law requires as been sign	lete			24a. Was an	24b. Were aut	opsy findings available			
he la e has age 2	Completed		-	autopsy performed:	prior to c death?	ompletion of cause of			
VICAL ician: 1 certificat ector, pi	a	25. Was case referred to medical	26. Place of Death (C	1 Yes 2 Pi	No IL Yes	2 No			
Physici Physici rthis ce	To B	examiner?  1 Yes 2 No Hospital: 18 Inpatient 2 ER/Outpatient 3	0.4		6 ☐Other (Spec	ıfy)			
ing Pl		27. Manner of Death 1. ☐ Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at 28d Work?	. Describe how in					
ttendi death ttor: A	cat	2 Accident investigation M	1 Yes 2 No	1		10-11			
OVISION  I or Attending after death.  Director: After in by the fune	Certification;	4 Homicide determined determined building, etc. (Specify)	tory, office 281.	City or Town, Sta	and Number or Ru ate)	ral Houte Number,			
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funers! Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the		29a. Certifier Check only 20 Medical Examiner: On the basis of examination and/or investiga	red at the time, date and place, and	due to the cause	(s) and manner as	stated.			
the H nin 24 the Fi nplete	fedical	one) and manner stated.							
T with	Σ	29b. Signature and title of certifier	29c. License number		Date signed (Month				
		20 Name and address of proper with correlated course of trails (for 202) 7	20073280		Jon 15,	200,			
3		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  DR. Sun i L Cupta G25 Keut Avenue	Cumberland	& CM,	21202				
Sta	ate	31. Date filed (Month, Day, Year)  32. Relistrar's Signature							
Regist	rar	NOV 2 3 2005 June 15 19							

31. Date filed (Month, Day, Year) State NOV 0 9 2005 Registrar



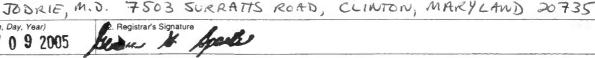
State

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

31. Date filed (Month, Day, Year) NOV 0 9 2005

TERRY



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

NOVEMEBER 4,2005

		4	For Stata Registrar	State of	Maryland / I		rtment of H		d Mental Hy	giene Reg. Ná	2005	27020		
			1. Decedent's Name (First, Middle, Last)  2. Date of Death									3. Time of Death		
	Physicia		JAMES	т.				Month NOVEMB		Day Year 4:30 P M				
	/Medic Examin		4a. Facility Name (If not institution		JORDAN ber)		4b. City, Town, or	Location of D			. County of Death	111333		
			PRINCE GEORGE H				CHEVERL				INCE GEO	RGE		
	Funeral		5. Social Security Number	6. Sex 7 12 M 2 ☐ F	7. Age (In yrs. last bi	rthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. (Month, D	irth ay, Year)	9. Birth	olace (State or Foreign		
	Director		245-58-3526 Usual Residence of Decedent		66				APRIL	2,19	39 NORTH	ĆAROLINA		
	yland		10a. State 10b. County		10c. City, Tow		cation					10d. Inside City Limits		
	e Mar	ctor	MD PRINCE	GEORGE	LANDOV	ER						1 XYes 2 No		
	or 28	Director	10e. Street and Number				10f. Zip Code				tizen of What Cou	ntry?		
	s 236		7206 E. INWOOD		dent Ever in U.S.	10.1	20785	i- Osisin	2 (Consider Venner N	U.S	14. Race - Ameri	oon Indian		
	ter de	Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Mar	Armed Ford	ces?	13.	Yes, specify Cubar	n, Mexican, P	? (Specify Yes or N uerto Rican, etc.)	0-	Black, White,			
99	urs a	þ	3 Widowed 4 Divorced	If Yes Give			I□Yes 2½□No	Specify:			Specify: BLA	.CK		
21215-0036	within 72 hours after death with the Maryland ene. Than "natural", or Items 23e or 28e-f show in Mudical Exami actinual te notified at	Completed	15. Deceder	nt's Education st grade completed)	16a	. Deced	lent's Usual Occupa kind of work done d	tion uring most of	f working	16b. K	(ind of Business/In	dustry		
12	vithin ne. han	du	Elementary/Secondary (0-12)	College (1-	4or 5+)	life. L	OO NOT use retired)							
N	filed v Hygie othar t	e Co	12th 17. Father's Name (First, Middle,	Last)		ROO	M OPERATO		Name (First, Middle		RIVATE Sumame)			
au	lid be lental kad o	To Be	FELIX JORDAN	,				CARRIE			,			
Maryland	should and Men is marka	۲	19a. Informant's Name/Relations	ship (Type, Print)			-		or Rural Route Num	-		Code)		
	and 2 lealth a m 27 is		ELSIE JORDAN/WI	FE				STREE	T LANDOVE	ER, M	D 20785			
Baltimore,			20a. Method of Disposition  1 ▼ Burial 2 □ Cremation 3 □ Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)  Date 20c. Location - City or Town, State											
tim	t. Partmen rtent: njury		`4 Donation 5 Other (Specify) FT. LINCOLN CEMETERY   11-10-2005 BRENTWOOD, MD											
Bal	permit. Pages 'Department of H Importent: If ite any injury or of once.		7474 LANDOVER RD LANDOVER, MD 20785									ME		
			23a. Part1. Enter the disease, o shock, or heart failure. Lis	r complications that ca t only one cause on ea	used the death. Do	not ent	er the mode of dying	, such as ca	rdiac or respiratory	arrest,		Approximate Interval Between Onset and Death		
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	-a. H7	popue	ع ر	nees	hal	opal	5		Criser and Death		
			rosulary ar doubly	Due to (c	or as a consequence	of):	11	1		H				
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (c	of):	as f	402	wac	Co	2				
	outed id ansit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events											
o,	ficate be executed physician and s the burial-transit		resulting in death) Last	Due to (d	or as a consequence	9):								
8760,	hysic the bu	dical		d										
9	ding p	0	IF FEMALE:	23c If yes outo	ome of pregnancy				. //		22d Date of dollar			
Вох	death certifi e attending p id for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?    1								23d. Date of delivery  Month Day Year			
0	0 0 0	hysi	1   Yes 2   No 9   Unknown											
S, P	requires that the een signed by th hould be detache	by P	Part II. Other significant condition	ons contributing to de-	ath but not resulting	in the u	nderlying cause give	n in Part I.	23e. Did	tobacco	use contribute to t	he cause of death?		
ord	w require been sig should b								1	Yes 2	es 2⊠No 3□Probably 4□Unknown			
Record	aw as b 2 sl	ompleted							24a. Wa					
E B	Th ate pag	Con							per 1 ☐ Yes	formed?	death? 1 ☐ Yes	2 No		
Vital	Physician: this certific ral director,	Be	25. Was case referred to medica examiner?	Hospital:			Othe		Death (Check only					
of		To To	1 Yes 2 No	28a. Date o	patient 2 ER/O finjury 28b.	utpatien Time of	t 3 DOA	" 4 ☐ Nursii	ng Home 5 Res 28d. Describe			(y)		
on	th. : After s funera	tlon	1 Natural 5 ☐ Pendi			Injury	28c. Injury Work M 1 □ Y	? ′es 2⊡No	1		,			
Division	el or Attending s after death. af Director: After ad in by the fune	Certification:	3 Suicide 6 Could 4 Homicide determ	nined 286. Place	of Injury - At home, f	arm, str	eet, factory, office		28f. Location	(Street ar	nd Number or Rura	al Route Number,		
	itel or rs afte af Dir led in	Cert	Tomodo	Dulidii	g, stc. (Specify)				Only of 70	Juni, State				
	To the Hospitel or within 24 hours after To the Funeral Discompletely filled in	edical	29a. Certifier 1 Certifyi (Check only one) 1 Medical	ng Physician: To the I Examiner: On the ba and mann	sis of examination a	ge, death nd/or inv	n occurred at the time restigation, in my op	e, date and p inion, death (	place, and due to the occurred at the time	cause(s , date an	) and manner as s d place, and due to	tated. o the cause(s)		
	To the within To the compl	Me	29b. Signature and title of certific	er //			29c. License	number		29d. Da	te signed (Month,	Day, Year)		
)			1/1/2	ton			03	303/	5	111	4/05			
12	(6)		30. Name and address of person				Print)	,			//			
	U		JAMES CAPEVENIS  31. Date filed (Month, Day, Year	MD, 3001				LY, MD	20785					
	Sta Registi		NOV 0 8	2005	egistrar's Signature	400	B							

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Deeth 1. Decedent's Name (First, Middle, Last) Month Physician 8 2005 November 1526 PM Eartha L. Johnson /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Prince George's Ft. Washington Ft. Washington Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Day, Yeer) | Aug. 23, 10 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Funeral 1□ M 2 🛣 F Yrs. 1916 89 South Carolina 129-18-5780 Director Usual Residence of Decedent deeth with the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits th and Mental Hygiene. 7 is marked other than "natural", or items 23s or 28s-1 shov traumstic event, the Modical Examiner must be notified at 1 X Yes 2 □ No Directo Maryland | Prince George's Ft. Washington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20744 12021 Livingston Road United States by Funerai 12. Was Decedent Ever in U,S. Armed Forces? Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours efter 1 ☐ Yes 2 🛣 No If Yes, Give 1 ☐ Never Married 2 ☐ Married Specify: Black Baltimore, Maryland 21215-0020 1 ☐ Yes 2 🗓 No Specify: 3 Nidowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Pastor Private 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Geneva Jones Benjamin Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a important: if Item 27 is any injury or other tra 2311 Thornknoll Drive, Ft. Washington, MD 20744 Deatrice D. Tyner/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 11/14/05 Landover, MD Harmony Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) Stewart Funeral Home 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 4001 Benning Rd., N.E. Wash., DC 20019 own Dewar 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lin. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner for use es the buriel-transit or Attanding Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Due to (or as a consequence of): ate hes been signed by the e pege 2 should be detached to Parf II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown δ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed TUYES BLOTTO 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) edical Certification: To 1 Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1. Natural 5 ☐ Pending 1 Yes 2 No investigetion death. irector: A 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Dire 4 Homicide within 24 hours e To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 11-8,05 D42953 chil 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11701 14 washington 10the

Registrar DHMH 16 Rev 6/95

State

31. Date filed (Month, Day, Year)

NOV 1 0 2005

. Registrar's Signature

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				State of Ma	arylanu					Wental IT		00	0 5	07	001
			Decedent's Name (First, Middle, Les	oet)			runca	te oi	Death	2. Date of D	Reg. N	10C U	UD	3/	931
	Physicia	an	Gwendolyn A.	•						Month	C	еу	Year		e of Death
	/Medic		4a Fecility Neme (If not institution, give				Co		4b. City, Town, o	NOV r Location of Dea		, 20 c. County	05	air	50 P.M.
1	Examin	er	Saint Thomas		ahil.		Cent	er	100						
	Funeral		5. Social Security Number 6. S		e (In yrs. les		) If Unde	r 1 Year		s. 8. Date of B	irth .	LINC	e Ge	elace (Sta	es InTraac
	Director		579-64-2238 Usuel Residence of Decedent	□ M 2□¥	87	Yrs.	Months	Days	Hours Mir	April					
	land land		10a. State 10b. County		10c. City,	Town or Le	ocation						1	0d. Inside	e City Limits
	72 hours efter death with the Maryland naturel; or items 23s or 28s-f show dical Examiner must be notified at	ģ	Maryland Prince	Georges	Hva	ttsv	7ille	ъ. М	arvlan	4				1 💢 Y	′es 2□No
	or 28	Director	10e. Street end Number					p Code	ar j rain	<u></u>	10g. C	itizen of \	Whet Cour	ntry?	
	th wi	a	4922 La Salle F	≀oad			20	782			Tri	nid	ad,	Taba	ago
	items items	Funeral	11. Meritel Status	12. Was Decedent I Armed Forces?		13.	Was Dece If Yes, spe	dent of H	lispanic Origin? ( an, Mexican, Pue	Specify Yes or Norto Rican, etc.)	lo-		e - Americ		,
20	s efta	by Fi	1 Never Married 2 Married	1 ☐ Yes 2X N If Yes, Give	No		1 🗆 Yes					Specify	<i>r</i> :		
8	72 hours eff "naturel", or	象	3 ☐ Widowed 4 1 ☐ Divorced	Yeer or Dates:		16a Doco	dent's Usu	ual Occur	ation		16h	Kind of R	B1 usiness/In	ack	
15	_	et	15. Decedent's Ed (Specify only highest gre	de completed)		(Give	kind of wo	ork done use retire	during most of word)	orking	160.	KING OF BU	13111623/111	Justry	
21215-0020	within iene.	Completed	Elementery/Secondary (0-12)	College (1-4or 5 3years		Nurs			,		N	ledi	cal		
ğ	other vent, ii	Be C	17. Father's Neme (First, Middle, Last)						18. Mother's Na	ame (First, Middl					
<u>la</u>	ould be Mental arked o	To B	John Solomon						Flora	nce Pre	esco	tt-	Solo	mon	
Maryland	should and Men a market		19a. Informant's Name/Relationship (7	Гуре, Print)		19b. Maili	ing Addres	s (Street	and Number or F	Rural Route Num	ber, City	or Town,	State, Zip Code) 33414-4347		1217
	nit. Peges 1 and 2 should be filed within tranent of Health and Mental Hygiene. ortant: If item 27 is marked other than Injury or other traumatic event, the High. 8.		Aubyn Jones/Sor	1	2	53 B	Berno	er	Walk.We	est Pal	m F	eacl	554 h F1	oric	1347 1a
ore	of He		20a. Method of Disposition  1X Burial 2 □ Cremation 3 □	Removal from State	20b. Pla	ce of Disponentery, crea	osition (Nã matory or	íme of other plac	Walk,We	Sat.	Bre	ntwo	City or To	wn, State	· ·
Ē	Peges ment of ant: If its ury or o		4 Donation 5 Other (Specify		Ft.	Lin	colr	. Ce	metery	Nov.12	Mar	vlai	nđ		
Baltimore,	permit. Peges Department of Important: If it any Injury or once.		21. Signature of Funeral Service Licen	see ,		2	2. Name a	nd Addre	ss of Facility	Latney'	s				
ш	20 E 2 9		Calph W.	llaam	L	3	831	Geo	rgia A	ve.,N.W	7. W	ash	D.C	.200	11
			23a. Part1. Ent of the disease, or comp shock, or heart failure. List only	olications that caused one cause on eech lir	the death.	Do not en	ter the mo	de of dyir	ng, such as cardia	ac or respiratory	arrest,		ere e la como	Approxin Interval E	nate Between
	Physician												j t	Onset ar	nd Death
	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	aAr	ryth	mia							1	4 ye	ars
		7	, , , , , , , , , , , , , , , , , , , ,		Due to (or a								1		
	ted nsit	듵		Respiratory Arresst/distress								1	2 hr	's	
	execun n and ial-tra	Exa	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of):  Chronic obstructive lung disease								1			
68760,	rificeta be executed g physician and as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events	Ç,	Due to (or a				ve rung	alsea	se			ye	ears
89	± 5° €	P	resulting in death) Last						Failure	2				mont	hs
Вох	th cer tendir r use	and		d									1		
<u>.</u>	a dea he at hed fo	sicl	Part II. Other significant conditions co	ontributing to death bu	ut not resulti	ng in the u	ınderlying	cause giv	en in Pert I.	23b. Dic	tobacc	O USE COI	ntribute to	the caus	se of death?
P. 0.	v requiras that tha death cer been signed by the attendir should be datached for use	by Physiclan/M	Obesity							10	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown				
Š,			ODCBICY										0.45 147		ou findings
Ö	requi hould	eted	G - tube feed	inq						24a. Wa per	s an aut omed?	opsy	av	ailable prid	sy findings or to of cause
နို	The law requirss that tha death cer ate has been signed by the attendir pega 2 should be datached for use	Completed										22000 C		mpletion of death?	
a	icate r, peg		25.11									XIN:	1 [	Yes 2	:□ No
₹	sicienti certii irecto	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:	nt 2□EF	1(Out-atia-	-+ 2 D	OA Oth	Or:	ath (Check only		a 🗆 🗆			
ō	Attending Physicien: or deeth. sector: After this certific. by the funeral director,	<u>1</u>	27. Manner of Death	28a. Date of Injur (Month, Dey		3b. Time o		28c. Injur Wor	4 Li-Nursing	Home 5 ☐ Res 28d. Describe				/)	
<u></u>	ath. Afte e fun	흝	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		rear)	Injury	М		k? Yes 2∐No						
	Atta ecto by th	200	3 ☐ Suicide 6 ☐ Could not be determined	28e. Plece of Inju	ry - At hom	e, farm, str	reet, factor	y, office		28f. Location City or To			er or Rura	l Route N	umber,
<u></u>	rs aft al Dir ad in	Certification:		Janamy, 616	(орослуу					ony or re	, 0.0	,			
	To the Hospital or Attanding Physicien: The law within 24 hours after deeth.  To the Funeral Director: After this certificate has completely filled in by the funeral director, pega 2	Medical	(Check only Z Medical Exam	ysician: To the best on the basis of	examination	edge, death n end/or in	h occurred vestigation	at the tin	ne, date and plac pinion, death occ	e, and due to the urred at the time	cause(	s) and ma	nner as st	ated.	e(s)
	To the Vithin 2 To the Complet	New A	29b. Signature and title of certifier	end manner sta	ited.				e number				d (Month,		
	Z ≥ 5 8	_	ROLL	DT	0.	, ,	-	710	7/19		11	LJ .	-	, , , , , , , , , , , , , , , , , ,	,
	111	)	30. Neme end eddress of person whip of	completed assessed	noth /ltc= 2	20) /7:	Drint\	<u> </u>	100 (		11.	7'	U 3.		
1	217		6/2 FT	PDU 5	T (ILOIII 2	1/7	KI	111	ipin A	10 2	7.71	7			
	Stat	e	31. Dete filed (Month, Day, Year)		er's Signatur		-, 4	1///		1	- 11	_			
	Registra	-	NOV 1 0 2005	Klance	K	Los	1								

DHMH 16 Rev 6/95

			1 - For State Registrer	State of	Maryland / Do	epartme Ce <i>rtifica</i>				lental Hy	giene	000	37932
	Physici	an	1. Decedent's Name (First, Mid							2. Date of De Month	Da	y Year	3. Time of Death
	/Medic	cal	ODESSA  4a. Facility Name (If not institution)	LUCILLE	JOHNS		Tour			NOVEMBE			9:46 A M
	Examin	er	PRINCE GEORGE		1001)		VERLY	r Location (	or Death			: County of Deat RINCE GE	
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. last birth	day) If Unde	r 1 Year	If Under		8. Date of Bi	rth		onplace (State or Foreign untry)
	Director		241-28-5023	1□M 2ÅF	80 Y	S. Months	Days	Hours	Min.	(Month, Da 09-23-	1925	NORT	H_CAROLINA
	and w		Usual Residence of Decedent  10a. State 10b. Coun	tv	10c. City, Town	or Location							10d. Inside City Limits
	Marylan f show	ō		E GEORGE	SEAT PL								Mais on y Emiles
	r 28a	Funeral Director	10e. Street and Number			10f. Z	p Code				10g. Ci	tizen of What Co	untry?
	th with 23a o Ist be	ai D	10 PEPPER MILL	DRIVE		20	743				Ü	J.S.A.	
	ter dea	ner	11. Marital Status	Armed For	dent Ever in U.S. ces?	13. Was Dece	dent of H	ispanic Ori	igin? (Spe	ecify Yes or No Rican, etc.)	o-	14. Race - Ame Black, White	
36	ours after death with the Maryla ral', or Items 23a or 28a-f shov Examinar must be notified at	by Fu	1 ☐ Never Married 2 ☐ Ma 3 ☑ Widowed 4 ☐ Divorce	arried 1 ☐ Yes If Yes, Give	2X No	1 🗆 Yes		Specify:		,,		Specify: BL	
Ş	72 hours after death with the Maryland "natural", or Items 23a or 28a-f show citeal Examinar must be modified at		15. Decede	ent's Education	16a. D	ecedent's Usi	ial Occup	ation			16b K	and of Business/	ndustry
215	within 72 ene. then "na	plet	(Specify only high Elementary/Secondary (0-12)	est grade completed)		Give kind of wife. DO NOT	ork done	durina mos	t of worki	ng			
21	be filed within 72 hc ntal Hygiene. Id other then "natur event, Ire Medical	Completed	12th			SEC	RETAR	RY				GOVERNI	MENT
Maryland 21215-0036	be filed ntal Hygi ad other event, I	Be	17. Father's Name (First, Middle	e, Last)						(First, Middle	, Maider	Sumame)	
<u>₹</u>	should be not Mental markad c	٦ ا	UNKNOWN  19a, Informant's Name/Relation	nshin (Tune Print)	19h A	Azilina Addros	s (Street			MAYBON	as City	or Town, State, Z	in Code)
Ma	0 0 0		CAROL THOMAS		1220								335
ē,	es 1 and 2 of Health fitem 27 I		20a. Method of Disposition		20b. Place of D		me of			WASHIN		MD 207	
Ë			1 △ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other		OUANTIC			!	1-14	-2005	TRΤΔ	NGLE, VA	10
Baltimore,	permit. Pag Department Importent: any injury c		21. Signature of Europeal Service	e preced				s of Facili	ty JB	JENKIN	S FU	NERAL HO	)ME
_	205 2		4700	the same	)	7474 I	ANDO	VER F	RD LA	NDOVER	,_MD		
П			23a. Part1. Enter the disease, shock, or heart failure. Li	or complications that ca st only one cause on ea	used the death. Do no ich line.	t enter the mo	de of dyla	g, such as	cardiaco	r respiratory a	rrest		Approximate Interval Between Onset and Death
	nysician /Medical Examiner	i i	Immediate Cause (Final disease or condition resulting in death)	a. 12	Vocam	leaf	1	my	la	reli	13	7	
				Due	r as a consequence of							75	
	-	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (d	or as a consequence of				4			,	
	nd nd transil	Examine	that initiated events	1.60	rond		12	2/4	2	1	es	000	2
90,	be executed sician and burial-transit		resulting in death) Last	Due to (d	or as a consequence of	,5	1		)				
8760,	ate hy:	dlcal		d	Draw		>_						
9 xc	ath certific tending p or use as l	hysician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outo	ome of pregnancy							23d. Date of deli	/en/
Box	death e atter d for u	iciar	in the past 12 months?	4□Pregna	rth 2 🗌 Fetal death int at time of death	3 ☐Ectopic p 5 ☐ Other (s						Month	Day Year
		hys	9 Unknown	9□ Unkno	wn								
'n	requires that the een signed by th hould be detache	by P	Part II. Other significant condi	tions contributing to de-	ath but not resulting in the	ne underlying	cause give	en in Part I.		23e. Did t	obacco (		the cause of death?
ord	w requir been s should	ted								10	Yes 2	No 3□ Pro	bably 4 Unknown
e C	aw Is b	ompleted								24a. Was autoj	psy	prior to o	opsy findings available ompletion of cause of
-	ate Th	O	77.14							1 ☐ Yes	2 No	death?	2 No
Vital	90	o Be	25. Was case referred to medic examiner?  1 Yes 2 No	Hospital:	patient 2 ER/Outp	atient 3 D	Othe	0.00		(Check only o		a Clau	
of	g Phye er this eral di	$\vdash$	27. Manner of Death	28a. Oute o	Injury 28b. Tin		28c. Injury Work		_	8d. Describe		6 □Other (Spec y occurred	fy)
ion	Attending ir death. ector: After by the fune	atlo	- CONGOIN	tigation	n, Day Year) Inju	M		c? Yes 2 □i	No				
Division	al or Attending s after death. al Director: After ed in by the fune	Certification;	3 Suicide 6 Coul. 4 Homicide deter	mined 289. Place	of Injury - At home, farm g, etc. (Specify)	, street, factor	y, office		2	8f. Location (: City or To	Street an wn, State	d Number or Rui	al Route Number,
Ω	# 5 ± ± 1		20a Carrifor 12 Carrifo	in Physician T. B.									
	To the Hosp within 24 ho To the Fund completely f	edical	29a. Certifier (Check only one)	ing Physician: To the last Examiner: On the base and manner	sis of examination and/o	or investigation	at the tim , in my of	ie, date an pinion, dea	d place, a th occurre	nd due to the d at the time,	date and	and manner as place, and due	stated. to the cause(s)
	To the	Me	29b. Signature and title of certif			29	c. License	number			29d. Dat	te sig <b>p</b> ed (Month	/Day, Year)
)			) / Va	Torre			0	30	3/8		11.	176	
7	101		30. Name and address of perso	· ·	, , , ,				,		11/	1/0	7
	14		JAMES CAPEVENI		HOSPITAL D	RIVE CH	IEVER	LY, M	1D 20	785			
	Sta Registr		31. Date filed (Month, Day, Yea NOV 1 0	2005	gistrar's Signature	mele							

			For State	State of M	faryland / De	partment of He			ene . N2 0 0 5	37033
100	*	4	Registrar  1. Decedent's Name (First, Middle	e. Last)		or inouto or E	Journ	2. Date of Death		3. Time of Death
	Physici	_	Michael	Love	Joy			November	Day 2005	7:20 p.m.
	/Medic		4a. Facility Name (If not institution			4b. City, Town, or	Location of Death		4c. County of Death	*
1	Examin	GI .85. 2	St. Mary's	Nursing Ce	enter	Leo	nardtown		St. Ma	ary's
	Funeral		5. Social Security Number	6. Sex 7. A	Age (In yrs. last birthda	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birth	place (State or Foreign ntry)
*	Director		227-05-3102	1 <b>№</b> M 2□F	94 Yrs.	indiana bayo		Jan. 17		ryland
	pur *		Usual Residence of Decedent  10a, State 10b, County		10c. City, Town or	Location				10d. Inside City Limits
	Aaryla Febo	ō		Mary's			Ridge			1 ☐ Yes 2 € No
	28e-	Director	Maryland St.  10e, Street and Number	mary s		10f. Zip Code	Riuge	10	g. Citizen of What Cou	intry?
	3a or	١	49592 Bayne Roa	a d			20680	1	United Stat	-es
	me 2	Funeral	11. Marital Status	12. Was Deceder Armed Forces	nt Ever in U.S.	3. Was Decedent of His If Yes, specify Cubar	spanic Origin? (Spe	cify Yes or No-	14. Race - Amer Black, White	can Indian,
ထ္	or ite		1 Never Married 2 Married			1 ☐ Yes 2 █ No	Specify:	110411, 010.7	Specify: Who	
8	within 72 hours atter death with the Maryland one. than "natural", or iteme 23a or 28e-f ehow has deal Exartier must be notified at	d by	3 ₩Widowed 4 Divorced	Year or Dates						
21215-0036	"nat	Completed		nt's Education st grade completed)	(Gi	cedent's Usual Occupa ve kind of work done d . DO NOT use retired)	uring most of workir	ng '	6b. Kind of Business/ii	ndustry
7	within ene.	m d	Elementary/Secondary (0-12)	College (1-4o	r 5+)	ivil Serva		I	J.S. Govern	nment
0	Hygother.	BeC	17. Father's Name (First, Middle,	Last)	-		18. Mother's Name	(First, Middle, M	aiden Sumame)	
<u>a</u>	fenta fenta rked ric ev	To B	George Ale	exander Joy			Li	.11ie Lov	7e	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or iteme 23a or 28e-f show any injury or other traumatic event. The Medical Examination and Examination and Once.		19a. Informant's Name/Relations	hip (Type, Print)	19b. Ma	illing Address (Street a	nd Number or Rura	Route Number,	City or Town, State, Zi	p Code)
Σ	and 2 ealth n 27 l		Shirley Kovich	ı / Daughter		l Pine Str				
altimore,	of Hi		20a. Method of Disposition 1 ■ Burial 2 □ Cremation	3 Removal from State	cemetery o	position (Name of rematory or other place	e) ¦		0c. Location - City or T	
Ë	Pag tment tent: jury		4 Donation 5 Other (5		St. Mich	ael's Cem.		Control of the Contro	Ridge, Mary	
Bai	Separ Mpor mpor iny in		21. Signature of Funeral Service	Sul					Funeral Ho	
46.	401 8 G		Edward N. Brins 23a. Part1. Enter the disease, o							20650-0279 Approximate
્યું			shock, or heart failure. List Immediate Cause (Final	t only one cause on each	i line.					Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	u	state Cance as a consequence of):	r				
436	Examiner				as a consequence on,.					
-6-		ner	Sequentially list conditions, if any, leading to immediate	Due to (or a	as a consequence of):		-			
	cuted nd transi	Examine	Cause. Enter Underlying Cause (Disease or injury that initiated events	с.						
00,	death certificate be executed attending physicien and of for use as the burial-transit		resulting in death) Last	Due to (or a	as a consequence of):					
8760,	cate b	Physician/Medical		d					-	
9 x	eath certific attending pl for use as t	/Me	IF FEMALE:	23c, If yes, outcom	ne of pregnancy				23d. Date of deli	verv
Вох	eath atten for u	clan	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No			3 □Ectopic pregnancy 5 □ Other ( <i>specify</i> )			Month	Day Year
P.O.	that the de ed by the detached	hysi	9 Unknown	9□ Unknown	1					
		by PI	Part II. Other significant conditi	ons contributing to death	n but not resulting in th	underlying cause give	en in Part I.	23e. Did tob	acco use contribute to	the cause of death?
rds	w require been sig should b				<del>-</del>			1 ☐ Ye	s 2ÆNo 3□Pro	bably 4 Unknown
Vital Records,	S S	Completed						24a. Was an	24b. Were au prior to d	topsy findings available ompletion of cause of
Œ	The ate h page	ĕ						perform 1 ☐ Yes 2	ed? death?	2 <b>2</b> No
/ita	ysicien: Th is certificate director, pag	Be (	25. Was case referred to medical examiner?			T Onto	26. Place of Death	Check only one	)	
jo	Physicien:	2	1 ☐ Yes 2 🔀 No 27. Manner of Death	Hospital: 1   Inpa			4 Divuising Ho		nce 6 Other (Spec winjury occurred	ufy)
no		ion	1 KNatural 5 ☐ Pendi	ing 28a. Date of li (Month, li ligation	Day Year) Inju	y Work	(? Yes 2 □ No	200. 2000000000	w mary occurred	
Division	or Attending after death. Director: After in by the fune	fica	3 ☐ Suicide 6 ☐ Could	not be 28e. Place of	Injury - At home, farm,	street, factory, office			eet and Number or Ru	ral Route Number,
á	afte Dire	Cert fication:	4 Homicide	building,	etc. (Specify)			City or Town	, State)	
	ospite hours unera ly fille			ing Physician: To the be I Examiner: On the basis						
	To the Mospitel or Att. within 24 hours after de To the Funeral Direct completely filled in by the	ledical	one)	and manner						
	To Too	Σ	29b. Signature and title of certific	ar .	10	29c. License	5575		d. Date signed (Montl	i, Day, rear)
,			1		/ / / / / / / / / / / / / / / / / / / /		2113	/ No	ovember 16	, 2005
			Jennifer Schm	n who completed cause of	-		d Califa	rnia M	arvland 200	519
100	St. St.	ate	31. Date filed (Month Day, Year	32. Regi	istrar's Signature	NOLCII KOB	u, vallic	THEA, MA	arytanu 200	) <b>.</b>
	Regist		7701 ]	V 2005	the se man	and the same				

			1 - For State Registrar	State of N	Maryland		artment of H		nd Mental H	lygiene Rea. Ne	2005	370	334
2	Physici	an	1. Decedent's Name (First, Middle, Last)						2. Date of Month	Death Da	y Year	3. Time o	
	/Medie	cal		ames Man		Johnso			Novem				Рм
<i>)</i>	Examir	ner	4a. Facility Name (If not institution, give s		*		4b. City, Town, o	r Location of	Death	40	. County of Death		
	Server of the se		St. Mary's Nursin				Leonardt				t. Mary	S	
	Funeral		5. Social Security Number 6. Sex	7. A ]M 2□F	Age (In yrs. Ia		If Under 1 Year Months Days	If Under 24 Hours		Birth <i>Day, Year)</i>	9. Birth	place (State intry)	or Foreign
Δ.	Director		216-18-5961		8	8 Yrs.			June 12	2, 1917			
	pug *		Usual Residence of Decedent  10a. State 10b. County		10c City	, Town or Lo	cation					10d, Inside C	Maria Contra
	eho	'n	,		, , , , ,	,	oation						2. No
	Ne N	ecti	Maryland St. Mary's	S	Ho1	lywood	1						242110
	vith t	Director	10e. Street and Number				10f. Zip Code			10g. Ci	tizen of What Cou	ntry?	
	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "naturel", or Iteme 23a or 28a-1 show event, the Madical Exardinar mall be profilled at		43355 Johnson Road				20636			τ	JSA		
	er de	Funeral		<ol> <li>Was Deceder Armed Forces</li> </ol>	s?		Vas Decedent of H Yes, specify Cuba	ispanic Origii In, Mexican,	n? (Specify Yes or I Puerto Rican, etc.)	No-	14. Race - Amer Black, White		
36	or l	Y.	1 ☐ Never Married 2 Married	1 ☐ Yes 2 X	No		☐ Yes 2X No						
8	urel'.	d by	3 Widowed 4 Divorced	Year or Dates	:						Specify: Whi	te	
21215-0036	72 h	Completed	15. Decedent's Educ (Specify only highest grade	cation completed)		(Give	lent's Usual Occup. kind of work done o	durina most o	of working	16b. K	ind of Business/I	ndustry	
2	Aithin ne.	d L	Elementary/Secondary (0-12)	College (1-4o	r 5+)	life. E	OO NOT use retired	)	-				
7	ygie ygie rer ti		8			Mechan	ic				vice Stati	on	
Ī	tal H d otl	Be	17. Father's Name (First, Middle, Last)					18. Mother's	s Name (First, Midd	ile, Maiden	Sumame)		
Х	should nd Men marke umatic	၉	James Ernest Johnson						Rosalie Coo				
Maryland	2 sh and Is m		19a. Informant's Name/Relationship (Typ	oe, Print)		19b. Mailin	g Address (Street a	and Number	or Rural Route Nun	nber, City o	or Town, State, Zi	Code)	
	and ealth m 27		Phyllis Mattingly / Dau	ıghter		43360 .	Johnson Roa	d, Holl	ywood, Mary	land 2	0636		
ore	permit. Pages 1 and 2 should be filed within 72 hours after death with the Manylan Department of Health and Menial Hygiene. Important: If item 27 is marked other than "naturel", or iteme 23s or 28s-f show may injury or other traumatic event, the Medical Examiner must be publised at a		20a. Method of Disposition  1 \( \bar{\Delta} \) Burial 2 \( \bar{\Delta} \) Cremation 3 \( \bar{\Delta} \) Re	emoval from Stat		ace of Dispos metery, crem	sition (Name of natory or other plac	θ)	Date November	20c. Lo	ocation - City or T	own, State	
Ĕ	Pages ment of I ant: If it ury or o		4 Donation 5 Other (Specify)	omovar nom otat		les Memo	orial Garde	ns   1	9, 2005	Leon	ardtown, M	arvl and	
Baltimore,	permit. Departr Importa		21. Signature of Funeral Service License	9//	0	22	Name and Address	e of Eacility	10			diffand	
m	89 = 8		Michael XOITUT	Hardine	1	P.O	D. Box 270.	Leonar	Funeral Hom dtown, Mary	e, P.A land 2	0650		
	- Ng W		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that cause	ed the death.	Do not ente	er the mode of dying	g, such as ca	ardiac or respiratory	arrest,	0030	Approximat	te
	Physician		Immediate Cause (Final								0: - 20	Interval Bet Onset and	
1	/Medical		disease or condition resulting in death)	Due to (or a	o gen	1C 5	nock a	150	chemic	corc	Riomyop	eny	
H	Examiner			Acut	e Ro	en co O	Failux	00.				)	
	<u>(</u> W	Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	s a conseque	ence of):	, an luck						
	uted d ansit	Examiner	Cause (Disease or injury that initiated events	Dehu	Dia.	tion.	,						
Ć,	exection and ital-tr	Exa	resulting in death) Last	Due to (ora	s a conseque	ence of):							
8760	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	dlcal	d	Shoc	k								
89	ificat g phy as th	ed											
Вох	death certific attending p	<b>≥</b>	IF FEMALE: 23b. Was decedent pregnant	Sc. If yes, outcom							23d. Date of deliv	an/	
ň	leath atte	cla	in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 4□Pregnant :			Ectopic pregnancy Other (specify)				Month		Year
o.	at the de by the a stached	Completed by Physiclan/Me	9 Unknown	9□ Unknown									
J.	res that igned b be deta	ā	Part II. Other significant conditions conf	tributing to death	but not result	ting in the un	derlying cause give	en in Part I.	23e. Dio	i tobacco u	ise contribute to t	ne cause of d	leath?
ds,	uires sigr ld be	Q P	Comon At	D	istale				10	Yes 2	□No 3□Prot	ably 4 Du	Jnknown
Ö	w require been sign	ete	1 1: 6	, )				-	-				
Record	hysician: The law his certificete has b I director, page 2 s	dm	torte Steves	2						opsy		psy findings i mpletion of c	avaitable ause of
	cete		Concestive He	ubtail	a.	Den	witing		1 □ Yes	formed? 2000	death? 1 ☐ Yes	2 No	
Vita	iciar certif ecto	Be	25. Was case ferred to medi I examiner?	ospital:	/		104		Death Check only	опеј			
	Phys this al dii	ပ္	1 Yes 2 No	1 ∐ Inpat		R/Outpatient		4 Gartutsi	ing Home 5 Re			y)	
2	Attending Physician: In death. Sector: After this certific by the funeral director.	0	1 Sending 5 Pending	28a. Date of Inj (Month, D	ay Year)	28b. Time of Injury	28c, Injury Work		28d. Describe	how injur	y occurred		
Sic	Mtendi death. ctor: A y the fu	cat	2 Accident investigation 3 Suicide 6 Could not be					res 2 ☐ No					- 2
Division of		Certification:	4 ☐ Homicide determined	building, e	ntery - At hometic. (Specify)	e, farm, stre	et, factory, office		28f. Location City or To	(Street an own, State	d Number or Rura )	i Route Num	ber,
_	pitel urs a nurs a illed		00-0-45									_	- 3
	he Hoepitel on 24 hours aft he Funeral Di pletely filled in	IIca	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examin	er: On the basis	or examinatio	ledge, death on and/or invi	occurred at the time estigation, in my op	e, date and p inion, death	place, and due to the occurred at the time	e cause(s) e. date and	and manner as s	ated. the cause(s)	)
	To the Hospitel within 24 hours a To the Funeral I completely filled	Medical	29b. Signature and title of certifier	and manner s	iated.		29c. License						
	F 3 F 8		ARA	100			Loo. Eloeitse			230. Dat	e signed (Month,	uay, rear)	
			(10)				DS	621	01	() ,	17/05		
dl	·		30. Name and address of person who con	npleted cause of			rint)		0	0.0	*	190	
			31. Date filed (Month, Day, Year)	30 Daniel	trar's Signatu	1035	1 hree n	Jetech	rec. H	roth	word,	MO	20/36
	Sta Registra		NUV 1 8 2	005		Mar .	Cart .			9			

_			State of Maryland		artment of He			giene Reg. NZ 0 0 5	37935
	Physici	an	1. Decedent's Name (First, Middle, Last)				2. Date of Dea Month	Day Year	
	/Medi Examir	cal	MARY E. JOHNSO  4a. Facility Name (If not institution, give street and number)	N	4b. City, Town, or I	ocation of Death		4c. County of Dea	10:45A M
1	Examin	iei <sub>e</sub>	Shady Grove Nursing Home	!	-	ville		MONTGO	
	Funeral Director		5. Social Security Number 6. Sex 1 □ M 2 □ F 90	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Sept • 2	9. Bi	rthplace (State or Foreign ountry) Maryland
	and land		Usual Residence of Decedent           10a. State         10b. County         10c. City,	, Town or Lo	ocation				10d. Inside City Limits
	Mary P-f sho	tor	MD Montgomery	Ga	aithersb	urg			Yes 2□No
	a with the	ai Direc	10e. Street and Number 217 Booth Street		10f. Zip Code	0878		10g. Citizen of What C	•
36	gas 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If Item 27 is marked other then "netural", or Items 23a or 28e-f show or or or fire treumatic event, the Medical Examinar must be mailted at the control of the control	by Funeral Director	11. Marital Status  12. Was Decedent Ever in U.S Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	'	Was Decedent of His If Yes, specify Cuban 1 ☐ Yes 2 No	panic Origin? (Sp. Mexican, Puerto Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Wh Specify: B	ite, etc.
21215-0036	hin 72 hour B. Bn "netural Medical Er	Completed t	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give life. i	dent's Usual Occupat kind of work done du DO NOT use retired)	ion ring most of won	king	16b. Kind of Business Montgome	Mindustry ry County
N	12 should be filed within 7 and Mental Hygiene. Is marked other then "r reumatic event, the Med	Be	17. Father's Name (First, Middle, Last)  Elbert M. Johnson Sr.	T	eacher		ne (First, Middle, a McKea	Public  Maiden Sumame)	Schools
Maryland	hould d Men marke matic	P	19a. Informant's Name/Relationship (Type, Print)	10b Maile	Address (Street as			r, City or Town, State,	77-0-41
	1 and 2 s Health an tem 27 ls		Florence M. Gram- Niece	734	Clopper			ourg, MD	
nore	Pages 1 nent of He ant: If iter		20a. Method of Disposition  1 ☑ Surial 2 ☐ Cremation 3 ☐ Removal from State  1 ☐ Donation 5 ☐ Other (Specify)  20b. Pla  Cel  Mt.	metery, cren	sition (Name of natory or other place) n Cemete:	l I	Date	20c. Location - City of Beallsvi	
Baltimore,	permit. Pages 1 and Department of Health Importent: If item 27 eny injury or other tr		21. Sonatury of Funeral Service Licensee	22	2. Name and Address	of Facility S	nowden		Home, P.A.
			23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.						Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	(cd	A	ANC			Onset and Death
Е	Examiner		Due to (or as a consequence to sequentially list conditions,	ance of):	Ma.				
	uted I Insit	Examiner	if any, leading to immediate Due to (or as a conseque cause. Enter Underlying Cause (Disease or injury	ence of):					
8760,	cate be executed physician and the burial-transit	dicai Exa	that initiated events c.  Due to (or as a consequence of the consequen	ence of):					
687	tificate ig phys as the	ledic	d.						
О. Вох	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☑ No 9 ☐ Unknown  23c. If yes, outcome of pregnant 1 ☐ Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of dead 9 ☐ Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
ecords, P.	quires that the de an signed by the a ruld be detached t	by	Part II. Other significant conditions contributing to death but not result	ting in the ur	nderlying cause given	in Part I.	23e. Did to	bacco use contribute to	o the cause of death?
		Completed					24a. Was a autops perfori	sy prior to	utopsy findings available completion of cause of
Vital	Physicien: Th this certificate ral director, pag	Be (	25. Was case referred to medical examiner?			26. Place of Deat	th (Check only on		
of	Phys rthis raldii	T.	1   Tes 2   100   1   Inpatient 2   E	P/Outpatien 28b. Time of				ence 6 Other (Spe	cify)
ion	Attsnding I death. ctor: After y the funer	ation	1 ☐ Matural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation	Injury	28c. Injury a Work? M 1 TYe	s 2 No	250. 2000.150 11	ow injury occurred	
Division	after de Directo	Certification	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At hom building, etc. (Specify)	1e, farm, stre	eet, factory, office	Ī	28f. Location (Si City or Town	reet and Number or A. n, State)	ural Route Number,
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Medical C	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my know and manner stated.	ledge, death on and/or inv	occurred at the time, restigation, in my opin	date and place, ion, death occur	and due to the cred at the time, d	ause(s) and manner as ate and place, and due	s stated. to the cause(s)
	To the vithin To the complete	Me	29b. Signature and title of certifier		29c. License c	umber 3	2	9d. Date signed (Mont	h. Day, Year)
)	D		1 /1/12	-	54	5> 17		11-04	-05
			30. Name address of person who completed cause of death (Item 2	23a) (Type, I	Print) 8607 SIVer	2nd A	re suf	1c# Yoy B	
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signatu	Te Ap	will.	<del>'</del> '' (5)		- 110	

28c. injury at Work?

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number D52326

1 Yes 2 No

28d. Describe how infury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

11-02-05

29d. Date signed (Month, Dey, Year)

Physician /Medical Examiner

The law requires thet the death certificate be executed

Hospitel or Attending Physicien: 4 hours after death.

Director: /

To the Hospitel within 24 hours a To the Funerel completely filled

Division of Vital Records, P.O. Box 68760,

**Physician** 

/Medical

Examiner

10a State

Directo

Funeral

þ

Completed

Be (

**Funeral** 

Director

permit. Pages 1 and 2 should be tiled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or iteme 23a or 28a-f ehow enty injury or other traumatic event, the Medical Examination in collision and injury or other traumatic event, the Medical Examination in collision and injury.

Baltimore, Maryland 21215-0036

Examine by Physician/Medical Be Completed Certification:

27. Manner of Death

1 Natural 2 Accident

3 Suicide

29a. Certifier

Medical

4 Homicide

(Check only one)

29b. Signature and title of certifier

Conald.	Cottlemy 1170 ROCKVILLE PIKE	ROCKVII	LE, MD. 20852
23a. Part1. Enter the disease, or con shock, or heart failure. List ont	mplications that caused the death. Do not enter the mode of dying, such as cardiac or y one cause on each line.	respiratory arrest,	Approx Interva Onset
Immediate Cause (Final disease or condition	SEPSIS		07/367
resulting in death)	Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediale cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consequence of):		
that initiated events resulting in death) Last	c		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. ff yes, outcome of pregnancy 1		23d. Date of delivery Month Day
Part II. Dther significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco	o use contribute to the caus
		24a. Was an autopsy performed?	
25. Was case referred to medical examiner?	26. Place of Death	(Check only one)	
1 X Yes 2 No	Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Hom	ne 5 Residence	6 ☐Other (Specify)

State Registrar 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5 Pending

investigation

6 Could not be determined



28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28a. Date of Injury (Month, Day Year)

			For State Registrar	State of N	aryland		artment <i>tificate</i>			and Menta		ne 2.005	379	37
	Physici		Decedent's Name (First, Midd		LSIE K	EEFER				2. Date Mor Nove	of Death	Day 2005	3. Time of 5:30	Death A M
	/Medic Examir		4a. Facility Name (If not institution Kline Hospice	House				nt A	iry			4c. County of Deal	th .ck	
	Funeral Director		5. Social Security Number 219–18–8942 Usuat Residence of Decedent	6. Sex 1 □ M 2 1 F	age (In yrs. las		If Under 1 Months	Year Days	Hours	Min. Marc	of Birth oth, Day, Ye h Io,	9. Bird 2007 1924 Mar	thplace (State of cunty) Yland	r Foreign
	e Maryland le-f show	ctor	10a. State 10b. County Maryland Frede:			Town or Lo							10d. Inside Ci	
	th with th	ral Directo	10e. Street and Number 124 Taney Avent	ue			10f. Zip (	2170	2		10g.	Citizen of What Co		
9800	be filed within 72 hours after death with the Maryland stal Hygiene. ed other than "natural", or Itams 23a or 28e-f show event, the Medical Eventral terroillied at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Mar 3 ☒ Widowed 4 □ Divorced	If Van Chia	:? ]No	4	Vas Decede i Yes, specif	_	panic Oric , Mexican Specify:	gin? (Specify Yes , Puerto Rican, e	or No-	14. Race - Ame Black, Whit Specify: W		
Baltimore, Maryland 21215-0036	id within 72 h giene. er then "natu	Completed	15. Deceder (Specify only higher Elementary/Secondary (0-12)	nt's Education est grade completed) College (1-4or		(Gîve life. L	lent's Usual kind of work DO NOT use Homema	done du retired)	îon iring most	of working	16b	. Kind of Business/ Own Ho		
/land	2 should be filed and Mental Hygis Is marked other sumatic event, It	To Be (	17. Father's Name (First, Middle, Stokley Linwood					1		r's Nam <i>e (First, I</i> Lydia C.				
, Man	12 sho h and 7 Is m traum		19a. Informant's Name/Relations Susan C. Jackso			19b. Mailin 1192	g Address ( North	Street an Marl	ket S	ror Rural Route Street,	Number, Cit Freder	ty or Town, State, 2 Cick, MD	Zip Code) 21701	
imore	Pages 1 and ment of Healt ent: If item 2' ury or other		20a. Method of Disposition 1 ☐ Burial 2X Cremation 4 ☐ Donation 5 ☐ Other (5		e cem	etery, cren	sition (Name natory or oth g Cren	er place)		Date . 1/11/20		Location - City or nithsburg		and
Balt	permit. Page Department of Importent: If any injury or once.		21. Sign were of Funeral Service	Licensee	lux	/ R <sup>2</sup>	BERT <sup>and</sup> 01 NOI	Address RTH N	ATTEY MARKE	& SON, I	FUNERA FREDEF	AL HOMES, RICK, MD	P.A. 21701	
*	Pnysician /Medical Examiner	10	23a. Part1 Enter the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	aDue to (or a	sa consequer	Conot ente							Approximate Interval Bety Onset and D	veen
,8260,	icate be executed physician and s the burial-transit	dical Examiner	cause Enter Underlying Cause Chisance I righty that initiated events resulting in death) Last	cDue to (or a	s a consequer	nce of):								
.O. Box 6	that the death certific ed by the attending p detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 ☐Fetal de	eath 3	Ectopic prec Oth <i>er (spec</i>					23d. Date of deli Month		'ear
Records, P	w requires that been signed b should be deta	by	Part II. Other significant conditi	ons contributing to death	but not resultin	ng in the un	derlying cau	ise given	in Part I.	23e		o use contribute to		
	The law ate has b page 2 sl	e Completed					-			10		prior to death?	topsy findings a completion of ca	variable luse of
ion of Vital	Phys this al dii	To B	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death Natural 5 Pendir 2 Accident investi	Hospital: 1 ☐ Inpat		Outpatient b. Time of Injury		Other: . Injury a Work?	4 □ Nur		] Residence	jury occurred	spice ,	ilou@
Division	s after des	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ained 286. Place of II	njury - At home tc. (Specify)	, farm, stre	et, factory,	office			tion (Street or Town, Sta	and Number or Ru ate)	ral Route Numt	9 <i>01</i> ,
	To the Hospital or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Medical (	29a. Certifyir (Check only one)  Certifyir 2 Medical	ng Physician: To the bes Examiner: On the basis and manner s	ot examination	dge, death and/or inv	occurred at estigation, in	the time, my opin	, date and nion, death	place, and due to occurred at the	o the cause time, date a	(s) and manner as and place, and due	stated. to the cause(s)	
)	Tot rot	M	29b. Signature and title of certifie	or ,			-	icense r			29d. C	Date signed (Month	, Day, Year)	
-	9		30. Name and address of person Hemen Shuh	who completed cause of	homas	Sa) (Type, F	rint) Urscu	Di	F	redenn	ck r	16,217	02,	
	Sta Registr	_	31. Date filed (Month, Day, Year)	0 2005 32. R	homas rar's Signature	H A	porti	,						

		1 - For State Registrar	State of Marylar		artment of H			ne N2005	37938
Physicia		1. Decedent's Name (First, Middle, Last)	Kohl				2. Date of Death Month	Day Year	3. Time of Death
/Medica Examine		4a. Facility Name (If not institution, give s Subukban (†	street and number)		4b. City, Town, of Berlin If Under 1 Year	r Location of Death	hanjand	4c. County of Deal	owers
Funeral Director		5. Social Security Number 6. Sex Usual Residence of Decedent	7. Age (In yrs.	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye 3 - 24-	9. B/m	hplace (State or Foreign funtry) New York
ne Maryland 8a-f show	ctor	10a. State 10b. County  Maryland Montgome		y, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
h with th	al Dire	10e. Street and Number 1801 E. Jefferson	Street		10f. Zip Code 20852			Citizen of What Co	-
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury gesther traumatic event, the Madical Examinar must be notified at once.	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cub 1 ☐ Yes 2 🗓 No	dispanic Origin? (Specan, Mexican, Puerto F	cify Yes or No- lican, etc.)	14. Race - Ame Black, White Specify: Wh	e, etc.
Baltimore, Maryland 21215-0036 sernit. Pages 1 and 2 should be filed within 72 hours all bepertment of Health and Mental Hygiene. In program: If item 27 is marked other than "natural", or any injury easther traumatic event, the Madical Exemples.	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation e co <i>mpleted)</i> College (1-4or 5+)	(Give life.	dent's Usual Occup kind of work done DO NOT use retired Lit Manag	during most of workin d)	9	Men's App	
yland 2 ould be filed Mental Hygi sarked other satic event, 1	To Be Co	17. Father's Name (First, Middle, Last) Elias Kohl		0200	1101106	18. Mother's Name Celia N	(First, Middle, Maid		74101
e, Mar 1 and 2 sh 1 ealth and om 27 is m		19a. Informant's Name/Relationship (Ty)  David Kohl, Son  20a. Method of Disposition		4910	- 17th A	and Number or Rural	oklyn, N	Y 11204	
Itimorali. Pages rament of Parant: If ite		1 ☑ Burial 2 ☐ Cremation 3 ☑AR 4 ☐ Donation 5 ☐ Other (Specify)	We]	Llwood	sition (Name of natory or other place Cemetery	11/8/	2005 Pi	. Location - City or 'nelawn, I	
Balt permit. Departimport		21. Signalure of Funeral Service License				<sup>ss</sup> fle <b>Srew</b> Fu 1 St., NW,			20012
Filysician /Medical		23a. Part1. East the disease, or complie shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each line.	n. Do not ent		ng, such as cardiac or			Approximate Interval Between Onset and Death
Examiner	e	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseq Due to or as a conseq	lial	INERE	inn			Zweek
8760, sate be executed by sicien and the burial-transit	al Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or s a consequence	uence of):	us be	(ctermi	~		1 week
87 Sate cate the the	edical	d d	RENAI	\a	( COIZE				ayears
C/osc Oldo   Records, P.O. Box 6   The law requires that the death certific   see his been signed by the attending page 2 should be detached for use as	rnysician/me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of do 9 ☐ Unknown	déath 3	Ectopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year
ecords, P.C ecords, P.C law requires that the law requires that the last been signed by the strong be detact.	2	Part II. Other significant conditions con-	tributing to death but not resi	ulting in the un	derlying cause give	en in Part I.	23e. Did tobacc	-	the cause of death?
Vital Records, P.O. sicien: The law requires that the dentificate has been signed by the rector, page 2 should be detached.	ompiec	Preumani-	•				24a. Was an autopsy performed	? death?	opsy findings available ompletion of cause of
f Vita ysician: is certific director.	0	25. Was case referred to medical examiner?	ospital:		3C DOA Othe	26. Place of Death	Check only one		
On of V on of V ding Physi h. After this o funeral dire		27. Manner of Death 1 △Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	3 DOA 28c. Injun Work	4   Nursing Home	e 5 ☐ Residence ld. Describe how in	6 ☐Other (Speci ijury occurred	ify)
VISI VISI Atten or deat ector: by the	ermean	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify	me, farm, stre	M 1 []	Yes 2 No	If. Location (Street City or Town, St	and Number or Rui ate)	al Route Number,
FOHL,  Di  o the Hospital or  thin 24 hours affer  o the Funeral Dir  mpletely filled in		29a. Certifier 1 Certifying Physic (Check only one) 1 Medical Examin	ician: To the best of my knower: On the basis of examinat and manner stated.	wledge, death ion and/or inv	occurred at the time estigation, in my op	ne, date and place, an pinion, death occurred	d due to the cause I at the time, date a	(s) and manner as	stated. to the cause(s)
To the Comp	Ž	29b. Signature and title of certifier	Manle	en un		3443 M	10	Date signed (Month)	,
		30. Name and address of person who cor John M. Chandler,				oad, Bethe	sda. MD	20814	
State Registrar		31. Date filed (Month, Day, Year)	32 Registrar's Signa		eles				

37940 State of Maryland / Department of Health and Mental Hygiene [] [] 5 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 2005 **Physician** 3, 5:55P Nov. KANNEY VIOLA YOUNG /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Montgomery General Hospital Olney If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb. 6, 1926 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M 2 K Maryland Yrs 79 215-20-3333 Director Usual Residence of Decedent 10d. Inside City Limits deeth with the Maryland 10a. State 10b. County 10c. City. Town or Location 28a-f ehow injury or other traumatic event, the Medical Examinar must be notified at 1∰Yes 2 No by Funeral Director Silver Spring MD Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23a or U.S.A. 20906 14508 Homecrest Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or iteme 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Black 3 XWidowed 4 □ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) than ' College (1-4or 5+) Elementary/Secondary (0-12) Home Domestic 11th I Hygie 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be 1 nent of Health and Mental I ant: If item 27 te marked o Daisy Shackelford Elliott Parker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19a. Informant's Name/Relationship (Type, Print) 19441 St Johnsbury Ln Germantown, MD20876 Karen Brown- Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If eny injury or once. Mational Mem Pk11/9/2005 Laurel, MD n 5 ☐ Other (Specify) 22. Name and Address of Facility Snowlen Funeral Home P.A. 21. Signature of Funeral Service Licens 246 N. Washington St Rockville, MD20850 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. Ust only one cause on each line. Approximate ot enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of Examiner Stage Reval Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit end Due to (or as a consequence of) Box 68760. attending physicien Completed by Physician/Medical igned by the attending phys be detached for use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 2 Fetal death 3 Ectopic pregnancy Month Year Day 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes No 3 Probably 4 ☐Unknown page 2 should 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 2 funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Copatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending after death. 1 ☐ Yes 2 ☐ No М investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) npletely filled in by 4 | Homicide within 24 hours a 29a. Certifier antifying Physician: To the best of my knowledge, death conumed at the time idate and place; and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signatura 29d. Date signed (Month, Day, Year) MD 05 ŧ oleted cause of death (Item 23a) (Type, Print) Prince Philip Drive 81 0 32 Registrar's Signature 31 Date filed (Month, Day, Year) State

Registrar

**NOV 08** 

2005

		•	1- For State of Maryland	/ Department of Health and Me Certificate of Death		146/0 0007
	Physici	an	1. Decedent's Name (First, Miggle, Last)  Nobert Lucius			Day Year 3. Time of Death
	/Medio Examin		4a. Facility Name (If not institution, give street and number) Southern Maryland Haspi	4b. City, Town, or Location of Death  Add Linton  t birthday) If Under 1 Year   If Under 24 Hrs.		4c County of Death Prince Georges
	Funeral Director		5. Social Security Number  6. Sex  1 PM 2 F  7. Age (In ŷrs. /as  1 Usual Residence of Decedent	t birthday)  If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	ar) 9. Birthplace (State or Foreign Country) 920 South Carolina
	Maryland a-f ehow	ctor	10a. State 10b. County 10c. City,	ashington, D.C.		10d. Inside City Limits 1 ⊒ res 2 □ No
	th with the 23a or 28	Funeral Director	10e. Street and Number 3301 C Street, SE.	101. Zip Code 2001 9	10g.	Citizen of What Country?
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21215-0036	within ene. then "	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0·12)  77h  College (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of workin life. DO NOT use retired)  791/07	9	Kind of Business/Industry Private Industry
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-	s 1 and 2 should Health and Men tem 27 is merke other traumatic		Charles Lucas (Nephew)	19b. Mailing Address Street and Number or Rural 273 Street Art 18 - 00 Rural 7 - 19 - 19 - 19 - 19 - 19 - 19 - 19 - 1	ryland	20748
Baltimore	6 0 = 5		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	etery crematory or other place)		Location - City or Town, State  Ricerel, Muryland
Ball	permit. Pag Department: Important: eny injury o	ğ ,	21. Signature of Funeral Service Licensee  Alph E. Williams 76	22. Name and Address of Facility Relph Williams Fu. 7 1813 Potomac tve. S.C.	. Washi	ngton D.C. 20003
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	be executed sician and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence or injury that initiated events resulting in death) Last  Due to (or as a consequence or injury that initiated events resulting in death) Last			
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Vital Records,		Completed			24a. Was an autopsy performed 1 Yes 2	
Z K	Physician: 1 this certifical ral director, p	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 2 No Hospital: 1 ☐ Inpatient 2 ≥ EF	26. Place of Death  VOutpatient 3 □ DOA Other: 4 □ Nursing Hom		6 □Other (Specify)
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Divis	5 g g c	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At hombuilding, etc. (Specify)	e, farm, street, factory, office	8f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
	To the Hospital or within 24 hours after To the Funeral Director completely filled in	Medicai (	29a. Certifier (Check only one)    Certifying Physician: To the best of my knowle and manner stated.	edge, death occurred at the time, date and place, and n and/or investigation, in my opinion, death occurre	nd due to the cause d at the time, date a	o(s) and manner as stated. and place, and due to the cause(s)
	To the within 2 To the complet	W	29b. Signature and vittle of confiner	29c. License number D 0 0 5 3 9 9 0		Date signed (Month, Day, Year)
R	-(3)		30. Name and address of person who completed cause of death (Item 2:  ALI RAHIMAW MD 750	3a) (Type, Print)		101
	Sta Registr	(4)	31. Date filed (Month, Day, Year) NOV 0 9 2005	θ,		

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2:15 Рм Mary Vivian Love November 15, 2005 /Medical 4a. Facifity Name (If not institution, give street and number) 4c. County of Death 4h City, Town or Location of Death Examiner Saint Mary's 28215 Point Lookout Road Loveville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖾 F 87 Yrs. September 8, 1918 Director Maryland 217-36-6769 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10b. County 10a. State 10c. City, Town or Location 10d. fnside City Limits r then "naturel", or Iteme 23a or 28a-f ehow The Medical Examinar must be notified at 1 ☐ Yes 2 X No Maryland | Saint Mary's Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 28215 Point Lookout Road 20656 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White þ 3KWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Coffege (1-4or 5+) Elementary/Secondary (0-12) Own Home 12 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental by Important: If Item 27 is marked oth eny injury or other traumatic event 9DEB. Florence Rae Blair John Long 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda Louise Thomas / Daughter P.O. Box 213 Loveville Maryland 20656 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) November Metropolitan Crematory 17, 2005 Alexandria, Vir inia 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. 21. Signature of Funeral Service Licensee nichael Y.O. Box 270, Leonardtown, Maryland 20650 arden Part1. Enter the disease, or proplication hat caused the deal shock, or heart failure. List into one cause on each line. 23a. Part1. Enter the disease, or o not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ar Physician Coronary /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of defivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown should b Completed divretiz 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2/2 No has 1 Yes 1 Yes 2 600 Be 25. Was case referred to medical examiner? director, 26. Place of Death | Check only one Hospitaf: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 3 DOA 27. Magner of D th 28a. Date of fnjury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After t Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral ( Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and the of D6055682 attendina 05 of person who completed cause of death (fterm 3a) (Type, Print) 30. Name and address hree NotchAd #7052 Willanson Thomas 32. Registrar's Signature 31. Date filed (Month, NOV 1 8 State

DHMH 17 Rev 1/2001

Registrar

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Records,
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 37966 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** November 17 ROBERT 2005 CHARLES MILLER JR. 3:25 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death VA Maryland Health Care System Perry Point Cecil 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Feb 1 **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months 1**⊠**M 2□F 210-42-6916 Director 52 1953 Pennsylvania Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10b. County 28a-f show 10d. Inside City Limits Examiner must be notified at Director MD Ceci1 1 Yes 2 No E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with ŏ 108 Milestone Rd. 21921 U.S.A. Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2X Married 1 Yes 2 No 1970 If Yes, Give Year or Dates: -1974 ŏ þ 1 ☐ Yes 2 ☑ No Specify: White 3 ☐ Widowed 4 ☐ Divorced "natural", -1974Completed other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) markad other than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. 12 Welder Steel Fabricator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be fi and Mental H Be Robert C. Miller, Sr. Helen Sommers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) itam 27 i Robert C. Miller Sr. (father) 31815 River Park Rd. Millington, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 5 = 5 1 ☐ Burial 2 Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. \* 4 □ Donation 5 □ Other (Specify) Kent Cremation 11/18/05 Smyrna, DE. 21. Signature of Funeral Service Change Galena Funeral Home of Stephen 118 West Cross St. Galena, MD. L. Schaech 21635 M00510 23a. Part 1. Enter shock, or he r the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, eart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Prostate Cancer disease or condition resulting in death) Unknown /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Dusito (or as a consequence of): the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): physician law requires that the death certificate be Physician/Medical use as the attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy þ in the past 12 months?
1 Yes 2 No Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown certificate has been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 XUnknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy The 1 Yes 2 No 2□ No 1 Tes Attanding Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 4X Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA this the funeral s after death. 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide õ within 24 hours a To the Funeral I Hospital 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D52739 11/17/05 X 30. Name and address of person who completed dause of death (Item 23a) (Type, Print) Suresh Shandelya, M.D. VA Maryland Health Care System Perry Point, MD 31. Date filed (Month, Day, Year) 32. Agistrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

NOV 2 3 2005

			1 - For State Registrar	State of Maryl		artment of I		_	giene 005	37945
	Physici	an	Decedent's Name (First, Middle, Last				<u>.</u>	2. Date of De Month	eath Day Ye	3. Time of Death
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	Examir	ner	Prince George's		nter	Cheve		Death	4c. County of E	
	Funeral		5. Social Security Number 6. Se	x 7. Age (In )	rs. last birthday)	If Under 1 Year	If Under 24	4 Hrs. 8. Date of Bir	th 0	Birthplace (State or Foreign
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	and		Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Limits
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			30. Name and address of person who co						1-1-1	
			Ophnell Cumbers 31. Date filed (Month, Day, Year)	oatch, M.D.	8416 Cer	itral Ave	nue, Ca	pitol Heig	hts,Md. 20	)743
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	/Medi Examir		4a. Facility Name (If not institution, gi				4b. City, Towr	, or Location		Novembe		+ 2005 County of De	
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	Funeral Director			Sex 7. Ag	e (In yrs. las	st birthday) Yrs.	If Under 1 Ye Months Day	ar   If Unde	er 24 Hrs.	8. Date of Bir (Month, Da Jan • 5	th ay, Year) 192	9. 8	hirthplace (State or Foreign Country) 1mington, NC
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	Page T	0								perfor 1  Yes	med? 2. No	death?	3 2 □ No
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	eath. or: Af the fur	catlo	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	1	reary	Injury		ork? ∐Yes 2∐i	No				
2	tel or Attendi s after death. el Director: A ed in by the fu	Certification;	3 Suicide 6 Could not be 4 Homicide determined	building, etc.						City or Tow	n, State)		ural Route Number,
	he Hospi in 24 hou he Funer pletely fill	edical	29a. Certifier (Check only one)  Check only 2 Medical Exam	ysician: To the best of niner: On the basis of and manner stat	avanimianon.	dge, death and/or inve	occurred at the testigation, in my	time, date an opinion, deal	d place, and th occurred	d due to the cat the time, d	ause(s) a ate and p	ind manner as place, and due	s stated. e to the cause(s)
1	To t	Σ	29b. Signature and title of certifier	ALLA			29c. Licen	se number		2	9d. Date	signed (Mont	h, Day, Year)
	0		30. Name and address of person who	completed cause of de	ath (Itam 00	a) (Tuno "	rint\	D4240	03		Nov	ember	7, 2005
/	(10)			Mathur, M.	D. 10	6 Irv	ing St.	, N.W.	, Sou	th Tow	er,	Wash.,	DC 20010
1	Stat	_	31. Date filed (Month, Day, Year)	2. Registrar	's Signat <del>ure</del>								

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** IRENE MBA-JONAS OCTOBER 25, 2005 6:25A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death HOWARD COUNTY GENERAL HOSPITAL COLUMBIA HOWARD Funeral 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 1 M XX Year) 1931 Days Hours Months Min. 10. 217 47 5846 Director 74 Yrs FEB. NIGERIA Usual Residence of Decedent death with the Maryland la or 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits XXYes 2 No MARYLAND HOWARD **JESSUP** Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ns 23a 9931 GUILFORD ROAD 20794 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ŽŽNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. r than "natural", or Item the Medical Examinar Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 Yes XXNo þ 3€ Widowed 4 Divorced BLACK Specify: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12TH HOMEMAKER OWN HOME other other treumatic event. 17. Father's Name (First, Middle, Last) es 1 and 2 should be fill of Health and Mental H I item 27 is marked oth 18. Mother's Name (First, Middle, Maiden Sumame) Be PETER IBARI NNE IBARI 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9931 GUILFORD ROAD VICTOR MBA-JONAS / SON JESSUP, MD 20794 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition

XX Burial 2 ☐ Cremation 3 ☐ Removal from State Date 20c. Location - City or Town, State Pages 1 nent of P ant: If ite ary or ot artment ortent: / injury / \* 4 ☐ Donation 5 ☐ Other (Specify) FAMILY CEMETERY 01/07/2006 | MBERI, IMO STATE, NIGERIA permit.
Departr
Importe
any inju 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
MARSHALL'S FUNERAL HOME OF MARYLAND, INC. 4308 SUITLAND ROAD SUITLAND, MD 20746 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest should or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final disease or condition resulting in death) Onset and Death Se **Physician** PSIS /Medical Due to (or as a consequence of): Examiner Cirrhosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) as the burial-transit Auto Manney BXBC Due to (or as a consequence of) Box 68760 the attending physician pg Physician/Medical d IF FEMALE: 980 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy Po in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. Yes XXNo detached 9 Unkno signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 HYPERTENSION Completed 1 Tes XX No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No certificate has autopsy perform 1 Yes XX No the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: XX Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 5 1 ☐ Yes XX No this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death Certification: 28b. Time of Aiter 28d. Describe how injury occurred XXNatural 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funerel Director: in by the 6 Could not be 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cal 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 11/7/05 062386 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PRESTON KIM 10801 HICKORY RIDGE RD. COLUMBIA, MD 21044

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

NOV 1 0 2005

2. Registrar's Signature

		•	For State Registrar	State of Marylan		artment of I tificate of			iene -2.005	37948
			1. Decedent's Name (First, Middle, Last)					2. Date of Deat Month		3. Time of Death
	Physici /Medio			ERTO MORAN				Novembe	r 6, 2005	5:20 a. <sup>™</sup>
12	Examir	er	4a. Facility Name (If not institution, give st Viers Mill Road, so	Parkw	ay	Rockv			4c. County of De	ery
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. 1	Ven	Months Days		8. Date of Birth (Month, Day,	Year) 9. B	irthplace (State or Foreign Country)
· ·	Director		NONE Usual Residence of Decedent			·		FEB. 2,	1984 G	UATEMALA
	nyian how	_	10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
	Be-f	Director	MD MONTGOME	RY	SILVE	R SPRING	3		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1 Yes 2 No
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	death ms 23	Funeral	12918 NEOLA RD.	2. Was Decedent Ever in U.	S. 13. )		JO Hispanic Origin? (Sp pan, Mexican, Puerto	ecify Yes or No-	14. Race - Ar	nerican Indian,
36	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "naturat" or Items 23a or 28e-f show event, I'm Mcdicel Exemprat must be notified at	by Fur	1 Never Married 2 Married 3 Widowed 4 Divorced	Amed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		fYes, specify Cub I X Yes 2 □ No	Specify:	LEMALAN	Specify:	hite, etc. HISPANIC
9	2 hou		15. Decedent's Educa	ation	16a. Deced	lent's Usual Occu	pation		16b. Kind of Busines	
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äry	s 1 and 2 should be f Health and Menta item 27 is marked other traumatic ev	은	ABUNDIO ROBERTO  19a. Informant's Name/Relationship (Typ)		19b. Mailin	g Address (Stree		PERANZA al Route Number,	City or Town, State	, Zip Code)
	alith a		ABUNDIO ROBERTO MO	RAN (FATHER)	1291	.8 NEOLA	RD., SILV	ER SPRIN	IG, MD 209	06
Baltimore,			20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ Re		lace of Dispo emetery, cren	sition (Name of natory or other pla		Date	20c. Location - City	or Town, State
Ë	Pages tment of I tent: If it		4 ☐ Donation 5 ☐ Other (Specify)	guat	_		etery 11/1		Peten, Gu	atemala
Ball	permit. Page Department of Importent: If eny injury of		21. Signature of Funeral Service Licenses	0		Name and Addr		YTON FUNER		
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ita		BeC	25. Was case referred to medical examiner?				26. Place of Deat	1 Yes 2 h Check only one	-	93 2 10
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on C	ding P. h. After 1 funera	ion:	27. Manner of Death 1 □Natural 5 □ Pending	28a. Cate of Injury (Month, Day Year)	28b. Time of Injury	Wo	ryat ork? ]Yes 2 No	28d. Describe ho	winjury occurred	ot
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			For	State of Marylan				2007	07010
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п	Physici	- 31	Joseph A	. Notop	oulos		Month	Day 200.	5 5130 PM
	/Medic Examin		4a. Facility Name (If not institution, give			y, Town, or Location of Deatl		4c. County of Dea	
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			5. Social Security Number 6. S		last birthday) If Und	YOSE AA/E er 1 Year   If Under 24 Hrs.		9. Bi	thplace (State or Foreign
12	Funeral Director			MM 2□F 7	Yrs. Month	Bays Hours Min.	June 2	Year) C	PA PA
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	land ow		10a. State 10b. County	10c. Cit	y, Town or Location				10d. Inside City Limits
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	eath na 23	era	11. Marital Status	12. Was Decedent Ever in U.				14. Race - Am	erican Indian,
	Hen d	Ë	1 Never Married 2 Marned	Armed Forces? 1 XYes 2 ☐ No	If Yes, sp	edent of Hispanic Origin? (S secify Cuban, Mexican, Puert	o Rican, etc.)	Black, Whi	
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an	od to	Be	George	A. Noto	poulos	Anna	K. B	eres	
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	1 and Health tam 27		20a. Method of Disposition	20b. P	Place of Disposition (A	ame of	Date	Oc. Location - City of	Town, State
ō	Pages nent of i		1 Burial 2 Cremation 3	Removal from State	emetery, crematory of	other place)	21205	York,	
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Baltimore,	permit. Page Depertment o Important: If eny Injury or once.		21. Signature of Funeral Service Licer	( 1 /	Ke FF	and Address of Facility	Home, In	6 9021	17 Rose Ave
	⊄□ = • a		- V.1	apper	17713			Jork,	PA17403
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Division of Vital Records,	or At after of Direct in by	Certification:	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	этнө, тагт, street, fact y)	огу, опісе	City or Town	reet and Number or R , State)	urar moute rvumber,
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	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificete has completely filled in by the funeral director, page 2.	edical	(Check only 2 Medical Exar	nysician: To the best of my kno niner: On the basis of examina	wiedge, death occurre ition and/or investigati	ed at the time, date and place on, in my opinion, death occu	e, and due to the ca erred at the time, da	iuse(s) and manner a ite and place, a <i>n</i> d du	s stated. e to the cause(s)
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ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1 Decedent's Name (First Middle Last) Month Physician Charles Chota Nanches November 5, 9:15 A. 2005 /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Takoma Park Washington Adventist Hospital Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) August 10,1938 North Carolina 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 XM 2 ☐ F 67 Yrs 245-50-5794 Director Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County ral', or Items 23a or 28a-f show Exeminer must be notified at 1X Yes 2 No Director District of Columbia Washington 10g. Citizen of What Country? 10e. Street and Number 115 Division Avenue, N. E. 20019 United States 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after 1 XYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced I Hygiene. other than "natura ent, the Medical E Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 2 Food Services Carry-Out Owner vears other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be th and Mental H 7 is marked of traumatic ever Colon Roone Lillie Arno1d 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 Is
any Injury or other trau Golethia Harris Nanches (Wife) 115 Division Avenue, N.E.; Washington, D.C. 20019 20b. Place of Disposition (Name of cemetery, crematory or other place) Nov. 9, 2005 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) National Harmony Memorial Park Landover, Maryland Signature of Funeral 960 <sup>22</sup>, Name and Address of Facility R. N. Horton Company Morticians, Inc. 600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Accident/Stroke **Physician** ere brovascular 7 nays /Medical Due to (or as a consequence of) Examiner FIVE YEARS ypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physicien and the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed three months failure Kenal Due to (or as a consequence of) Box 68760. FIVE YEARS Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1XYes 2⊡No 3⊡Probably 4⊡Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy 1 ☐ Yes 2 ☐ No 2 XI No 1 Yes Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ဂ After this funeral c 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: Date of Injury (Month, Day Year) 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Direct 4 Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier ical (Check only one) Medi and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier envan spugge mo 00051670 NOVEMBER 6, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SPRING STREET SUITE ZOU SILVER SPRING MO 20910 TOWANA SPRIGES MD 1400 31. Date filed (Month, Day, Year) State NOV 0 8 2005 Registrar

	V		1 - State Registrar  1. Decedent's Name (First, Middle, Lasi	State of Mar			t of H	ealth ar	nd Me	Re 2. Date of Death	ene g. No. (	2005	3795 3. Time of Death
>	Physic /Medi Exami	ical	Gilbert Need  4a. Facility Name (If not institution, give  Suburban Hospita	street and number)		Вє	thes	Location of C	Death	Novembe:	4c. C	2005 County of Deat	12:35AM
	Funeral Director		Usual Residence of Decedent	M 2□F	In yrs. last birthday) 88 Yrs.	Months	1 Year Days	If Under 24 Hours	Hrs. Min.	8. Date of Birth (Month Day April 2	Š <sup>ear)</sup> 1	917 <sup>9. Birt</sup>	hplace (State or Foreign untry) ash. D. C.
	72 hours after death with the Maryland natural", or itema 23a or 28a-f ahow disal Examiner must be reditled at	al Director	Maryland Montgome  10e. Street and Number  11430 Strand Drive	ery	Oc. City, Town or Lo Rockville	10f. Zip	Code 20852	)		10		on of What Co	10d. Inside City Limits  1 Yes 2 □ No  untry?
-0036	hours after deal tural; or itema?	ed by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: ₩₩	Army	Was Deced 1 Yes, spec	ent of Hi fy Cubar	spanic Origin n, Mexican, F Specify:	? (Spec Puerto R	ify Yes or No- ican, etc.)	14	I. Race - Ame Black, White	
Maryland 21215-0036	I within iene. r than	Be Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 12 Years 17. Father's Name (First, Middle, Last)			kind of wor DO NOT us	k done d e retired) Men	chant		g 10	P1u	mbing	Industry
	2 should be and Menti is marked is marked in m	To B	Morris Needle  19a. Informant's Name/Relationship (Ty Brian D. Needle				(Street a	Pear I	l Br	enner Route Number, G	City or 1	own, State, Z	ip Code) 0852
Baltimore,	rtmen rtant: njury		20a. Method of Disposition  1 X Burial 2 Cremation 3 F  4 Donation 5 Other (Specify)	emoval from State	20b. Place of Dispo- cemetery, cren King Davi	sition (Name natory or ot d Men	ne of her place 1. Go	lns   11	Da 1/6/	2005 1	oc. Loca Fall	ition - City or 1 S Chur	
Ba	Depa Depa Impo any id		21. Signature of Funeral Service License Cornel Cor	tottler	10	91 Rc	ckvi	11e P	ike.	Direct: Rockvi Rockvi respiratory arres	11e.		Approximate
	The law requires that the death certificate be executed  X  X  The law requires that the death certificate be executed  X  X  X  X  X  X  X  X  X  X  X  X  X	dical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	onsequence of):  chasequence of):  onsequence of):	- h	Car	A f	211	ure			Interval Between Onset and Death
P.O. Box 6	that the death certifice ted by the ettending ph detached for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	3c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3	Ectopic pre Other (spe					230	I. Date of delive	rery Day Year
ords, F	w requires that been signed I should be det	à	Part II. Other significant conditions con	tributing to death but n	ot resulting in the un	derlying ca	use giver	in Part I.				contribute to t	the cause of death? bably 4 Unknown
		Be Completed	25. Was case referred to medical examiner?		- 10			26. Place of I	Death (6	24a. Was an autopsy performe 1 Yes 2		e4b. Were auto prior to co death? 1 ☐ Yes	opsy findings available ompletion of cause of
ion	nding Physath. r: After this e funeral di	유	1   Yes 2   No	28a. Date of Injury (Month, Day Ye	At home, farm, stre	M 28	Other c. Injury a Work?	4 ☐ Nursin	g Home 280	5 Residence	injury o	ccurred	fy) al Route Number,
Ω	To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by th	ledical Cer	29a. Certifier f Certifying Phys (Check only 2 Medical Exemin one)	cian: To the best of mer: On the basis of exa	v knowledge death	occurred at	the time	, date and pla nion, death o	ace, and	1 do a table	-(-)	d manner as s	stated. o the cause(s)
)	To within compo	2	29b. Signature and title of certifier	hus		(	License (	all components	9	29d.	Date si	igned (Month,	Day, Year)
	Sta Registr	te	30. Name and address of person who co	1 ted cause of death  1	8600 Old	rint) Georg	etow	n Rd.,	Bet	chesda,	MD.	20814	

DHMH 17 Rev 1/2001

Needles

Gilbert

			For State Registrar	State of Ma	aryland		artment			ind M		jiene	000	
			Decedent's Name (First, Middle, Last)		•						2. Date of Dea Month	th	UU5 Year	G Time of Death
	Physici /Medio		ALICE MARY	OLSEN							Novembe		2005	2:30 A M
7	Examin	er	4a. Facility Name (If not institution, give : 2101 Country Pines					Town, or I Idorf	Location of	f Death		4c. (	Charles	•
	Funeral		5. Social Security Number 6. Sec	7. Age	e (In yrs. la	ast birthday)	If Under	1 Year	If Under 2		8. Date of Birth	) 		place (State or Foreign
	Director		348-34-4//0	M 2CXF	63	Yrs.	Months	Days	Hours	Min.	(Month, Day Feb. 28	, 19	42 [11]	inois
	and bw		Usual Residence of Decedent  10a. State  10b. County		10c. City	, Town or Lo	cation						1	0d. Inside City Limits
	Mary I-f sho	tor	Maryland Charles			Waldor	٠f							1 ☐ Yes 2 <b>X</b> ☐ No
	th the	Funeral Director	10e. Street and Number				10f. Zip	Code			1	0g. Citiz	en of What Cou	ntry?
	s 23e	rail	2101 Country Pines					20601		1.0.10	7		USA	Indian
	fter de	Fune	11. Marital Status  1 ☐ Never Married 2 ☐ Married	12. Was Decedent I Armed Forces? 1 ∐Yes 2 📉 N	ever in U.S Io				panic Orig , Mexican,	, Puerto I	cify Yes or No- Rican, etc.)		4. Race - Americ Black, White,	etc.
5-0036	72 hours after death with the Maryland naturel; or Items 23e or 28e-f show aled Exholiner must be natilised at	l by	3 X Widowed 4 □ Divorced	ff Yes, Give Year or Dates:			1 ☐ Yes 2	2 <b>(X)</b> No	Specify:				Specify: Wh	ite
5-0	"natu	Completed by	15. Decedent's Edu (Specify only highest grad	cation completed)		16a. Deced (Give	dent's Usua kind of wor DO NOT us	l Occupa k done di	tion uring most	of worki	ng	16b. Kin	d of Business/In	dustry
2121	within ene. than "	dwc	Elementary/Secondary (0-12)	College (1-4or 5	+)		nemake						Own Hor	ne
	a filed Il Hygi other	Be C	17. Father's Name (First, Middle, Last)				- Cilitaria		18. Mother	r's Name	(First, Middle,	Maiden S		
ylar	ould be f   Mental P   warkad of   watic eve	To E	Stanley George Bar	·loga		**					hy Mart			
Maryland	12 sho h and 7 is m treum		19a. Informant's Name/Relationship (Ty				•	•					Town, State, Zip	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or Items 23e or 28a-f show any injury or other treumatic event. Its Madical Exbrainer must be pullified at DDCs.		Jennifer Foster -  20a. Method of Disposition	<u> </u>	20b. P!	ace of Dispo	sition (Nan	ne of					ation - City or To	
D D	Pages ent of nt: If if		1 ☐ Burial 2 🂢 Cremation 3 ☐ F  4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		metery, cirer tt Cre	-			1-9-	2005	wa 1 d	orf, MD	
Baltimore,	permit. Departm Importe any inju		21. Signature of Funeral Service Licens	mo(	0053	22	2. Name an	d Address	of Facility	У	P. 0.	Box	156	
	99 = 59		Mark 13130	Kann			intt F					-	MD 20604	Approximate
	Physician /Medical Examiner	-	23a. Part. Enter the disease, or complishock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	Due to (or as	a consequ	ence of):		ce.	(	4	, toophatory an	031,		Interval Between Onset and Death
8760,	certificate be executed ding physician and isa as the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Inflor) that initiated events resulting in death) Last	,		,								
.O. Box 6	that the death certifica ad by the attending ph detached for usa as th	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal	death 3	Ectopic pro					2:	3d. Date of delive Month	ery Day Year
S, D		by P	Part II. Other significant conditions con	ntributing to death b	ut not resu	lting in the u	nderlying ca	ause give	n in Part I.		23e. Did to	bacco us	e contribute to t	ne cause of death?
Records,	The law requires ite has been sign bage 2 should be	ted						_			1 🗆 Y	es 2	No 3 Prob	pably 4 Onknown
3ec	e law has b	Completed									24a. Was a autops perfor	sv	24b. Were auto prior to co death?	psy findings available mpletion of cause of
Vital		e Co	25. Was case referred to medical						26 Place	of Dogsth	1 ☐ Yes	2 Alo	1 🗌 Yes	2 No
f Vi	Q 55	To B	evaminer?	lospital: 1  Inpatie	nt 2 🗆 E	ER/Outpatier	nt 3□ DO	A Othe		rsing Hor	1		Other (Specif	(y)
on of	Jing After fune		27. Manner of Death  1	28a. Date of Injur (Month, Day	Year)	28b. Time o Injury	M 2	8c. Injury Work	at ? es 2 □ N		8d. Describe h	ow injury	occurred	
Division	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	2 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	28e. Place of Injubuilding, etc	ury - At ho c. (Specify	me, farm, str	eet, factory				28f. Location (S. City or Town		Number or Rura	d Route Number,
	To the Hospital within 24 hours a To the Funerel I completely filled	edical (	29a. Certifier 1. Certifying Phy (Check only one)	sician: To the best oner: On the basis of and manner sta	examinat	vledge, death ion and/or in	h occurred vestigation,	at the time in my op	e, date and inion, deat	d place, a	and due to the co	ause(s) a late and p	and manner as s place, and due to	tated. o the cause(s)
	To th Withir To th compl	Me	29b. Signature and title of certifier	. 1	) ^			License					signed (Month,	Day, Year)
			1 Koyè 1	1 Ma	de		1	129	-3	)	)_	1)	17/0)	
d	RIO		30. Name and address of person who co	mpleted cause of d	eath (Item	23a) (Type,	Print)	e P	106	-	MS	2	066	1
	Sta	te	31. Date filed (Month, Day, Year)	32. Registra	ar's Signat	ure A	metal s	1	- 1			<u> </u>	-0 7	V

State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year Gordon Raynesford 0tis /Medical NOVEMBER 2005 5:58 T 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Hospital Leonardtown St. Mary's If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 MM 2 □ F Yrs. Director 041-12-0504 85 1919 Dec. 6, Indiana Usual Residence of Decedent death with the Maryland 10a, State show 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other then "naturel", or Items 23s or 28a-f shov other treumatic event, the Neglest Examinan har revitived at Directo 1 Yes 2 No Maryland St. Mary's Lexington Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 45916 Pine Road 20653 United States Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "naturel", or Iten any injury or other treumatic event, The Medical Evantina. once. ■Yes 2 No 1941-1 Never Married 2 Married altimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 Yes 2 No Specify: by Specify: White 3 ☐ Widowed 4 ☐ Divorced 1969 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Naval Aviator United States Navy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ೭ Clarence Wendell Otis Edna Cogswell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alice R. Otis / Wife 45916 Pine Road, Lexington Park, Maryland 20653 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State <sup>1</sup> 4 □ Donation 5 □ Other (Specify) Trinity Episcopal Cem 11-18-2005 St. Mary's City, MD Edward N. Brinsfield, Jr. 22. Name and Address of Facility Brinsfield Funeral Home, P.A. M00052 22955 Hollywood Road, Leonardtown, MD 20650-0279 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final consestive heart failuse Priyalcian disease or condition resulting in death) Days /Medical Due to (or as a consequence of): months Examiner Restochive cardiomyopathy Sequentially list conditions, any sealing to minimum accause. Enter Underlying Cause (Disease or injury Dua to (or as a consequence of): Examiner Months the death certificate be executed as the burial-transit Multiple Myeloma that initiated events resulting in death) Last Due to (or as a consequence of): GORDON RAYNESFORD OTIS Vital Records, P.O. Box 68760, the attending physician Physician/Medical use s IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) ☐Yes 2 ☐ No 9☐ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? pleural Effusion 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☒ No 24a. Was an autopsy 1 Tes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ★ Inpatient 2 □ EP/Outpatient 3 □ DOA 2 of After this Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending F after death. Division 1 Natural 2 Accident 5 Pending after death. investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospitel within 24 hours a To the Funerel C 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ical On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

and manner stated. (Check only one) 2 Medical Examiner: 29b. Signature and title of certifier 3vavial 29c. License number 29d. Date signed (Month, Day, Year) D61719 November 16, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DHANAN JAY BHAV
31. Date filed (MoNO), Jean BHAVSAR SHAH ASSOC HOLLYWOOD MD 20636 Registrar's Signature 2005 Registrar

			1 - For State Registrar	State of	Maryland / Dep <i>Ce</i>	artment of rtificate of			giene 005	37954		
	Physici		1. Decedent's Name (First, Middle ETHE)		ER			2. Date of Dea Month Nov.	Day 2005	3. Time of Death  1: pm M		
	/Medio Examir		4a. Facility Name (If not institution  Larkin-Chase				or Location of De		4c. County of De	ath		
-	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. last birthday,			drs. 8. Date of Birth	9 B	Georges irthplace (State or Foreign Country)		
	Director		578-38-9226 Usual Residence of Decedent	1□M <b>3</b> 4□F	90 Yrs.	Months Days	s Hours W	May 12	2,1915 Pi	reston, VA.		
	nyland show		10a. State 10b. County		10c. City, Town or L					10d. Inside City Limits		
	the Ma 28a-1 s	ecto	MD Prince	ce George	es Bo	10f. Zip Code			10g. Citizen of What (	1 ∑ Yes 2 □ No		
	ath with the Marylan s 23a or 28a-f show wat be recitied at	ai Di	15615 Ever	glade Lar	ne, Unit 10		716		U.S.A	-		
920	after de or Itams	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Mar  3 ☑ Widowed 4 ☐ Divorced	ried Armed For	217 No	Was Decedent of if Yes, specify Cul		(Specify Yes or No- erto Rican, etc.)	14. Race - Am Black, Wh Specify:			
15-0	C 2 3	eted		it's Education st grade completed)	(Give	dent's Usual Occu kind of work done DO NOT use retin	e during most of v	working	16b. Kind of Busines	s/Industry		
21215-0036	d within giene. er than "	Completed	Elementary/Secondary (0-12)	College (1-	4or 5+) ///e.	Homemal	*		Domes	stic		
Maryland	nit. Pages I and 2 should be filed within 72 hours ariment of Health and Mental Hygiene. ortant: If item 27 is marked other then "natural; injury or other traumatic event, the Martical Exage.	Be	17. Father's Name <i>(First, Middle,</i> Frank	Coates			18. Mother's N	Name (First, Middle, Agnes	Maiden Sumame) Hairst	on		
lary	2 should b and Ment Is markad sumatice	2	19a. Informant's Name/Relations					Rural Route Numbe	r, City or Town, State,			
	1 and Health am 27 Ither tr		Delorise Coat  20a. Method of Disposition	tes Niec	20b. Place of Disp cemetery, cre	The state of the s		The state of the s	20c. Location - City of			
Baltimore,	Pages nent of ant: If if	1	t Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		state   cemetery, cre   Marylan			11/12	Laurel	, MD		
Balt	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trai 2005.		21. Signature of Funeral Service	B. Him	17			_	neral Hom sh.D.C.20			
	Physician		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final	fiac or respiratory are	rest,	Approximate Interval Between Onset and Death						
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	xecuted and sl-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (c	or as a consequence of):							
8760,	icate be executed physician and s the burial-transit	dicai E		d								
P.O. Box 6	ath certif attending for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 Live bi	ant at time of death 5	⊒Ectopic pregnand □ Other (specify)	су		23d. Date of do Month	elivery Day Year		
	w requires that the deben signed by the should be detached	þ	Part II. Other significent conditi	ons contributing to de	ath but not resulting in the u	ınderlying cause g	iven in Part I.			to the cause of death?  Probably 4 □Unknown		
of Vital Records,	* 0.03	Completed		110				24a. Was a autops perfor 1 Yes	med?   death?	autopsy findings available completion of cause of s 2 \( \text{No} \)		
Vita	sician: certific irector,	Be	25. Was case referred to medica examiner?  1 Yes No	Hespital	patient 2 ER/Outpatie	nt 3□ DOA	thor	Death (Check only or	ne) ence 6 □Other (Sp			
on of	ding Phy h. After this funeral d	tion: To	27. Manner of Death  12 Natural 5 Pendir  2 Accident investi	28a. Date o	f Injury o, Day Year) 28b. Time of Injury	of 28c. Inju	4X Mulani	-	ow injury occurred	өспу)		
Division	l or Attan after deat Director:	Certification:	3 Suicide 6 Could 4 Homicide determ	not be 28e. Place	of Injury - At home, farm, st g, etc. (Specify)	reet, factory, office	•	28f. Location (S City or Town	treet and Number or F n, State)	Rural Route Number,		
_	To the Hospitel or Attending Physicien: The Is within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page?	Medical C			best of my knowledge, dea sis of examination and/or in er stated.							
	To th within To th compl	Me	29b. Signature and title of certifie	1	5	29ç. Licer	nse number		9d. Date signed (Mor			
2	(5)		30. Name and address of person Richard Felo				oad, La		20706	-		
	Sta Registr		31. Date filed (Month, Day, Year)	<b>22.</b> Re	ngistrar's Signature		•	<u> </u>				

			For State ( Registrer		partment of Health and ertificate of Death		ne 2005	37955
	Physici /Medic		Decedent's Name (First, Middle, Last)  JEAN	POTTS-	HARPER	2. Date of Death Month	Day Year 1, 2005	3. Time of Death 2:16 P M
	Examir Funeral		4a. Facility Name (If not institution, give street and not Prince George's Hospita.  5. Social Security Number 6. Sex	•	4b. City, Town, or Location of De- Cheverly y) If Under 1 Year   If Under 24 H	ath ]	4c. County of Death Prince Georg	rge's
*	<ul> <li>Director</li> </ul>		214-90-4796 1□M 2戻F Usual Residence of Decedent	39 Yrs.	Months Days Hours Mi	SEPTEMBE	R 9 MAR	ace (State or Foreign try) YLAND
	r 28e-f show	'n	10a. State . 10b. County	10c. City, Town or			10	0d. Inside City Limits
	or 28e-f	Director	MD PRINCE GEORGE 'S	S UPPER	MARLBORO 10f. Zip Code	10g.	Citizen of What Coun	25 -
	ath wit	ralD	13933 BISHOP BEQUEST RO		20772		.S.A.	
920	72 hours after death with the Maryland natural', or items 23a or 28e-f show dical Exantratrinual be notified at	by Funeral	Armed F	2 X No ive	B. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue  1 □ Yes   2 ☒ No Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - America Black, White, e	an Indian, etc. ACK
21215-0036	c * 4	Completed	15. Decedent's Education (Specify only highest grade completed Elementary/Secondary (0-12) College 12th	(Giv (1-4or 5+)	edent's Usual Occupation we kind of work done during most of w DO NOT use retired)	rorking	. Kind of Business/Ind	ustry
d 2	at the	Be Co	17. Father's Name (First, Middle, Last)	DEAC	JTICIAN  18. Mother's N	ame (First, Middle, Maid		
ylan		To B	WILLIAM POTTS SR.		ANETT	E D	AILY	
, Maryland	nd 2 lith a 27 ts r trau		19a. Informant's Name/Relationship (Type, Print)  ANGELO HARPER/HUS	BAND 1393	ling Address (Street and Number or I	RD. UPPER		20112
Baltimore,	Pages 1 aument of Hea ant: If Item ury or othe		20a. Method of Disposition  1X Burial 2 □ Cremation 3 □ Removal from 4 □ Donation 5 □ Other (Specify)	Jiaio	position (Name of ematory or other place)  D NATIONAL 11/		. Location - City or Tov AUREL , MARY	
Balt	permit. Pages Department of Important: If Is eny injury or once.		21. Signature of Kunga Service Licensee		22. Name and Address of Facility 7474 LANDOVER ROA			HOME 20785
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on Immediate Cause (Final disease or condition resulting in death)	each line.	nter the mode of dying, such as cardi			Approximate Interval Between Onset and Death
	scuted on the stransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  c.	(or as a consequence of):				
68760,	icate be executed physician and s the burial-transIt	edical Ex	resulting in death) Last Due to	(or as a consequence of):				
	certifica nding ph		IF FEMALE: 23c If yes ou	utcome of pregnancy				
P.O. Box	death e atter	Physician/M	in the past 12 months?	birth 2 Fetal death 3 nant at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of deliver Month	ry Day Year
	w requires that the been signed by th should be detache	by	Part II. Other significant conditions contributing to o	death but not resulting in the	underlying cause given in Part I.		co use contribute to the	
of Vital Records,	The law ate has b page 2 st	Completed	E			24a. Was an autopsy performed	?   death?	osy findings available apletion of cause of
Vita	Physicien: The this certificate al director, pag	o Be	25. Was case referred to medical examiner?  1 ☒ Yes 2 ☐ No Hospital: 1 ☐	Inpatient 2 XER/Outpati	Oth	eath (Check only one)	2.50	
ou of	ng ifter inei	on: To	27. Manner of Death  1 Natural 5 Pending  28a. Date (Mor	of Injury 28b. Time oth, Day Year) Injury	of 28c. Injury at Work?	Home 5 Residence 28d. Describe how in		)
Division	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place	e of Injury - At home, farm, s ling, etc. (Specify)	M 1 ☐ Yes 2 ☐ No street, factory, office	281. Location (Street City or Town, St	and Number or Rural ate)	Route Number,
	ne Hospita 24 hours ne Funeral	Medical C	(Check only 2 Medical Examiner: On the I	e best of my knowledge, deapasis of examination and/or nner stated.	ath occurred at the time, date and plan investigation, in my opinion, death occ	ce, and due to the cause curred at the time, date	e(s) and manner as sta and place, and due to	ited. the cause(s)
	To the vithin To the comp	M	29b. Signature and title of certifier	0 -	29c. License number		Date signed (Month, D	
12	(2)			ise of death (Item 23a) (Type	0.C.M.E.  Print) Penn Street, Ba		ember 2, 20	
1	Sta	te	31. Date filed (Month, Day, Year)	Registrar's Signature		TUTINOTE, M	iryranu 212	'OT
	Registr	_	NOV 0 8 2005	we I Ap	whi .			

8760,
). Box 68
3, P.C
Records
Vital
Division of

										Are Legible	
			1 - For State Registrar	State of Ma	aryland /		artment of h rtificate of	lealth and M Death	-	giene Reg. No. 005	37956
	Physic	ian	Decedent's Name (First, Middle, Last)						2. Date of Dea	ath	3. Time of Death
	/Medi	cal	General Bradford					/	Novem!	er 3, 200	5 5:40A M
	Exami	ner	4a. Facility Name (If not institution, give st		1			or Location of Death		4c. County of De	
	Funeral	Г	Doctors Community  5. Social Security Number 6. Sex		L e (In yrs. last bi	irthday)	Lanham If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	Prince G	
	Director		388-01-5784	M 2 F	95	Yrs.	Months Days	Hours Min.	(Month, Da) 8/31/1	O Oa	irthplace (State or Foreign Sountry) kland, Tenn.
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tow	vn or Lo	cation				10d. Inside City Limits
	Mary B-1 sh	tor	D.C.			Was	hington				1 ☐ Yes 2 💆 No
	or 28	Direc	10e. Street and Number				10f. Zip Code			10g. Citizen of What C	Country?
	sath w	erai	2551 17th					009		U.S.A	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked othar than "natural", or items 23a or 28a-1 show other traumatic avant, the Medical Evarter from the Cotified at	Completed by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	P. Was Decedent I Armed Forces?  1 ☑ Yes 2 ☐ If Yes, Give Year or Dates:			Vas Decedent of H f Yes, specify Cuba I ☐ Yes 2[2] No	tispanic Origin? (Spec an, Mexican, Puerto F Specify:	ify Yes or No- ican, etc.)	A:	
15-0	"natu	etec	15. Decedent's Educa (Specify only highest grade)	tion completed)	16a	(Give	lent's Usual Occup	during most of working	g	16b. Kind of Busines	s/industry
12	withir iene. than	dmc	Elementary/Secondary (0-12)	College (1-4or 5	+)		Commissi	oned Offic	er	II C A	ir Force
d 2	il Hygis othar	Be Co	17. Father's Name (First, Middle, Last)					18. Mother's Name			II FOICE
ylar	2 should be filed with and Mental Hygiene. is marked other that aumatic avant, the manatic avant, the manatic avant, the manatic avant, the manatic avant, the manatic avant, the manatic avant, the manatic avant, the manatic avant, the manatic avant, the manatic avant, the manatic avant, the manatic avant, the manatic avant, the manatic avant.	To B	George Paris					Narciss	us Tenr	nyson	
Maryland	12 sho hand 7 is mu		19a. Informant's Name/Relationship (Type	•						r, City or Town, State,	
	permit. Pages 1 and 2 Department of Health Important: If itam 27 I any injury or other tra once.	1 8	Darryl B. Paris/Gra	inason			Andean Go sition (Name of	oose Way,U		arlboro, Md. 20c. Location - City o	
Baltimore,	eg = to		1 ☐ Burial 2 X Cremation 3 ☐ Rer 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	cemete	ry, cren	natory or other plac	ce)		)5 Beltsvi]	
alti	permit. Pag Department Important: I any injury o	H	21. Signature of Funeral Service Licensee			22	Name and Addre	ss of Facility	0-	DETUSATI	rre, Ma.
	8 Q E 8 9		Many N.	-n	24	4	925 Burro	oughs Ave.	N.E.	Inc. Jashington,	D.C.20019
	Pnysician /Medical		23a. Part1. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	Renal	the death. Do le.  Failur  consequence	not ente	er the mode of dyin	ng, such as cardiac or	respiratory arr	est,	Approximate Interval Between Onset and Death
	Examiner		Sequentially list conditions, b.								
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events c.	Due to (or as a	consequence	ot):					
.09	be executed sician and burial-transit		resulting in death) Last	Due to (or as a	consequence	of):					
9289	ate be hysici the bu	licai	d.								
9 x	leath certificate b attending physic I for use as the b	/Med	IF FEMALE:	. If yes, outcome of	of programmy	-				Т.	
.O. Box	that the death certificate led by the attending phys detached for use as the	Physician/Medic	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live birth : 4 Pregnant at : 9 Unknown	2 🗌 Fetal death		Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
S, D	es thai igned t	by P	Part II. Other significant conditions contri	buting to death bu	t not resulting in	the un	derlying cause give	en in Part I.	23e. Did tob	acco use contribute to	the cause of death?
ord	law requires as been sign 2 should be	leted	Hypertension						1 🗆 Ye	s 2 No 3 P	robably 4 Allaknown
Vital Records,	The ate has page	Comple	Anemia						24a. Was a autops perform	y prior to	utopsy findings available completion of cause of 2 No
	Physician: Th this certificate al director, pag	o Be	25. Was case referred to medical examiner?	pital:			3C DOA Othe	26. Place of Death (			
o t		H .	27. Manner of Death	28a. Date of Injury (Month, Day	28b. T	ime of	28c. Injury	at 28		nce 6 Other (Spe	cify)
sior	Attanding I r death. actor: After by the funer	atio	2 Accident investigation	(MONIN, Day	rear) II	njury	M 1 1	<br Yes 2 □ No			
Division	of the Dirac	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injui building, etc.	ry - At home, fa (Specify)	rm, stre	et, factory, office	28	Location (Sti City or Town	reet and Number or Ri , State)	ural Route Number,
	To the Hospitel or At within 24 hours after or To the Funeral Direct completely filled in by	edicai	29a. Certifier   1	ian: To the best of On the basis of and manner stat	examination and	, death d/or inve	occurred at the timestigation, in my op	e, date and place, and pinion, death occurred	d due to the ca at the time, da	use(s) and manner as ite and place, and due	stated. to the cause(s)
)	Court Court	Σ	29b. Signature and title of centrier		M	1	29c. License	05829	0	Od. Date signed (Mont.	h, Day, Year)
12	(3/ IV	1	30. Name and address of person who comp DR, Suresh K. Mut	oleted cause of de	ath (Item 23a) ( 420 <i>3</i>	Туре, Р	rint) censbuly	Road, H	yattsv.	16 md.	20781
	Sta Registra	_	31. Date filed (Month, Day, Year)	39. Registrar	's Signature_	La.	K)	,			
DHI	MH 17 Rev 1/20		NOV 0 8 2005	Diam	No. 14				·		

			1 - For Stata Ragistrar	State of	Maryland / Dep <i>Ce</i>	artment of rtificate of		id Mental Hy	0001	5 37957
*	Physici /Medi		1. Decedent's Name (First, Middle C ( A R U =	2 S Lt.	PROFF	FIN,	JR.	2. Date of De Month Vovem	Day Ye	3. Time of Death
A. C.	Examir		4a. Facility Name (If not institution Howard County G	eneral Hos	pital	Col	n, or Location of E umbia		4c. County of E	3
-	Funeral Director		5. Social Security Number 216 18 4451 Usual Residence of Decedent	6. Sex 7.	Age (In yrs. last birthday 82 Yrs.	Months Day		Min. 8. Date of Bin (Month, Date of Cot 2,		Birthplace (State or Foreign Country) Maryland
	72 hours after death with the Maryland naturel', or teme 23a or 28a-1 ehow dical Evacinar most be rotified at	eral Director	MD Howa: 10e. Street and Number 2649 Orchard Ave	enue	10c. City, Town or L	City 101. Zip Cod 21	043		10g. Citizen of Wha United	States
21215-0036	in 72 hours after o n "naturel", or Iten Aedical Examinar	leted by Funeral	11. Marital Status  1 Never Married 2 Marri 3 Widowed 4 Divorced  15. Decedent (Specify only highes	If Yes, Give Year or Date t's Education	es?  No  as: unknown  16a. Dece (Give	1 Yes 1	No Specify: cupation ne during most of	? (Specify Yes or No luerto Rican, etc.)	Specify:	
d 2121	ited within Hygiene. Ther then nt, Ite Me	e Completed	Elementary/Secondary (0-12)  17. Father's Name (First, Middle, I	College (1-4 4 Last)	or 5+) Owne	DO NOT use ret		Name (First, Middle	Mid Atlar Microfilm Maiden Sumame)	
Maryland	2 should be f and Mental is le marked of aumatic eve	To B	Charles H. Prof:		19b. Mail	ng Address (Stre	Elna	Selman	er, City or Town, Stai	re. Zin Code)
Baltimore, Ma	permit. Pages 1 and 2. Department of Health ar Important: If Item 27 le any injury or other trau		Elinor W. Proffe  20a. Method of Disposition  1 Burial 2 Cremation  4 Donation 5 Other (Sp.  21. Signature of Funeral Service t	en/Wife 3 □Removal from Sta	2649  20b. Place of Disp. cemetery, cre Druid Ri M01044 2	Orchard osition (Name of matory or other p dge Ceme 2. Name and Add	d Avenue  olace)  etery 11-  dress of Facility ]	Ellicott Date -11-2005 Harry H. V	City MD 20c. Location - City Pikesvill Vitzke's F	21043 or Town, State
	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List of the shock is a shock of heart failure. List of the shock is a shock or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	only one cause on eac	sed the death. Do not en	ter the mode of o	tying, such as car	diac or respiratory a		Approximate Interval Between Onset and Death MINUTTS
Box 68760,	death certificate be executed e attending physician and id for use as the burial-transit	Physician/Medical Exar	that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	d23c. If yes, outcome		D∈ctopic pregnar	ncy		23d. Date of	•
P.O.			1 Yes 2 No 9 Unknown  Part II. Dther significant condition	9□ Unknow	n	Other (specify)		220 Did	Month	Day Year
ords,	law requires that the as been signed by th 2 should be detache	eted by	bilateral	Caro	t'd Stev	ics's	given in Part I.	10	res 2□No 3□	Probably 4 Unknown
tal Rec	performance death?									
of Vi	Physicien: this certificated director, I	The state of the s								pecify)
ivision	or Attending Iter death. Irector: After n by the funer	Certification:	27. Manner of Death    Statural   5   Pending	ation of be 28e. Place of	njury Day Year)  Injury - At home, farm, streetc. (Specify)	M 1	☐ Yes 2 ☐ No			Rural Route Number,
	Hospitel (24 hours a) Funerel D etely filled i	dical	29a. Certifier (Check only one)	g Physician: To the be Examiner. On the basis and manner	est of my knowledge, deat s of examination and/or in stated.	n occurred at the vestigation, in my	time, date and pl y opinion, death o	ace, and due to the	cause(s) and manner date and place, and c	as stated. tue to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. Lice	onse number	545	29d. Date signed (Mo	onth, Day, Year)
8	(2)		30. Name and address of person v	who ampleted cause of	of death (Item 23a) (Type,	Print) Lane,	Colum	bia, MD	Nov 5	
E	Sta Registr	-	31. Date filed (Month, Day, Year)  NOV 0 9	Att	istrar's Signature	parti)				

			For State	te of Maryland / Depa	artment of Health and N	•	<b>19</b>
			1 - State Registrar	Cei	tificate of Death	Reg. N	10.
	Physici	an	1. Decedent's Name (First, Middle, Last)	IMON DAYMAN			ay Year 3. Time of Death
	/Medi		GERALDINE MAE EGGLES  4a. Facility Name (If not institution, give street a		4b. City, Town, or Location of Death	November	
1	Examir	ier	St. Thomas More Nursi			4	c. County of Death
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	Hyattsville If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	Prince George's
П	Director		264-34-5111 <sup>1□ M 2</sup>	∑F 80 Yrs.	Months Days Hours Min.	(Month, Day, Year	9. Birthplace (State or Foreign Country)  New York
_	pu .		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo			
	Aaryli f sho	ō	,		cation		10d. Inside City Limits 1 X Yes 2 ☐ No
	the N 28a-	Director	Maryland   Prince Georg	ce's Cheverly	10f. Zip Code	10- 0	
	3a or	Ö	2302 Crestlawn Avenue				itizen of What Country?
	death ms 2	Funeral	11. Marital Status 12. Wa		20785 Vas Decedent of Hispanic Origin? (Spi Yes, specify Cuban, Mexican, Puerto		S.A.  14. Race - American Indian,
9	after or Ita	T	1 Never Married 2 Married 1	Yes 2 No		Rican, etc.)	Black, White, etc.
8	72 hours after death with the Maryland hatural', or Itams 23a or 28a-1 show JICM Externing must be notified at	d by	3 X Widowed 4 ☐ Divorced Yea	ar or Dates:	Yes 2 X No Specify:		Specify: White
21215-0036	"nat	Completed	15. Decedent's Education (Specify only highest grade comp	leted) 16a. Deced (Give	lent's Usual Occupation kind of work done during most of work DO NOT use retired)	ing 16b. I	Kind of Business/Industry
12	withi ene. than	dwc	Elementary/Secondary (0-12) Col	lege (1-40r 5+)	strative Work		££_11_0
b	Hyg other ant,	Be C	17. Father's Name (First, Middle, Last)	/Milli		(First, Middle, Maide	ffolk County, NY
<u>la</u> r	uld be Aenta rked tic ev	To B	George Stanley Eggle	ston	Ada Mae		,
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or Itams 23a or 28a-1 show any injury or other traumatic event, it a Modical Exercities must be notified at once.	-	19a. Informant's Name/Relationship (Type, Prin	nt) 19b. Mailin	g Address (Street and Number or Rura		or Town, State, Zip Code)
≥,	and and a salth m 27		Ann C. Barsi - Daugh		Crestlawn Avenue,	Cheverly,	Maryland 20785
Baltimore,	ges 1 t of H If Itan or oth		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Remova	20b. Place of Dispos	sition (Name of patory or other place)		ocation - City or Town, State
Ē.	tmen tant: jury		' 4 □ Donation 5 □ Other (Specify)	Congression	nal Cemetery 11/9	/2005 Was	shington, D.C.
Bal	Depar Depar Impor any in		21. Sign yure or Funeral Service Licensee	22	Name and Address of Facility Gas	ch's Funer	al Home, P.A.
			23a/Part1. Enter the disease, or complete ations	that assumed the death. Do not yet	739 Baltimore Ave	., Hyattsv	
	anni esta.	.	Immediate Course (Final	e on each line.		r respiratory arrest,	Approximate Interval Between Onset and Death
	Pnysician / /Medical		disease or condition resulting in death)	rkinson's Dement ue to (or as a consequence of):	ia		
	Examiner		Pr	ogressive Cognit	ive Decline		
	7 -	ner	Tariy leading to immediate	ua to (or as a consequence of):	ive beeime		
	acuted ind transi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  c.				
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	EX	resulting in death) Last	ue to (or as a consequence of):			
687	physi physi the b	dicat	d				
	eath certific attending p for use as	Physician/Medi	IF FEMALE: 23c. If ye	s, outcome of pregnancy			
Box	death a atter	iciar	in the past 12 months?	Live birth 2 Fetal death 3	Ectopic pregnancy Other (specify)	1	23d. Date of delivery  Month Day Year
P.O.	that the de ed by the a detached f	hys	9 Unknown 9	Unknown			
	res tha igned be del	by P	Part II. Other significant conditions contributing	g to death but not resulting in the un	derlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
ord	w require					1 ☐ Yes 2	X No 3 Probably 4 Unknown
e C	law ras be	Completed				24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
Vital Records,		Con				performed? 1 ☐ Yes 2 🕅 No	death?
<u> </u>	aician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?  Hospital:		26. Place of Death		
ō	Phys r this ral dii	- L	I Les SIV 140	1 ☐ Inpatient 2 ☐ ER/Outpatient Date of Injury 28b. Time of		ne 5 Residence	6 □Other (Specify)
0	th. : After s funer	tion	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at 2 Work? M 1 ☐ Yes 2 ☐ No	8d. Describe how injul	ry occurred
Division	al or Attandi after death. I Director: A d in by the fu	Certification:	3 Could not be	Place of Injury - At home, farm, stre		8f. Location (Street an	nd Number or Rural Route Number,
5	tal or s afte al Dir ed in	Cert	* _ Nonlicide	building, etc. (Specify)		City or Town, State	<del>)</del> )
	a Hospital or Attanding Physician: 24 hours after death. e Funaral Director: After this certificietely filled in by the funeral director,	edicai	29a. Certifier  (Check only 2 Medical Examiner: On	o the best of my knowledge, death	occurred at the time, date and place, a astigation, in my opinion, death occurre	nd due to the cause(s)	) and manner as stated.
	To tha P within 24 To the F complete		and	manner stated.		d at the time, date and	d place, and due to the cause(s)
	T V C	Σ	29b. Signature and title of certifier	240	29c. License number	29d. Da	te signed (Month, Day, Year)
	5	-		•	D0051122	Nov	ember 6, 2005
	61		30. Name and address of person who completed Esmerando 0. Juanitez	cause of death (Item 23a) (Type, P	rint) Providence Hosp	ital	D2 0001-
	Stat	е			m St. NE, Suite O	uo, Washin	gton, DC 20017
	Registra		110 1 0 5000 Decem	32. Registrar's Signature			

State of Maryland / Department of Health and Mental Hygiene 🕦 🖯 5 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** NOVEMBER 06, 2005 10:59A <sup>™</sup> GLADYS IRENE SAUNDERS /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 804 KAYAK AVENUE CAPITOL HEIGHTS PRINCE GEORGES If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1 M XX F Yrs. Director 577 36 9263 82 1923 WASHINGTON, DC JUNE 18, Usual Residence of Decedent death with the Maryland 10c. City, Town or Location or 28e-f show 10a State 10b Counts 10d. Inside City Limits Director MARYLAND PRINCE GEORGES CAPITOL HEIGHTS tXXYes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 804 KAYAK AVENUE 20743 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XX No If Yes, Give Year or Dates: item 27 is marked other then "natural", or items other treumatic event, the Medical Examination 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after in and of Health and Mental Hygiene. In and of Health and I started other then "natural", or lite, marked other then "natural", or lite in any or other treumatic event, the Marical Exam har 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes XX No Specify: by Specify: BLACK XX Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10TH CLERK NAVAL RECIEVING STATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be NELSON DYER CARRIE DYSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CAPITOL HEIGHTS, MD 20743 RAYMOND ECHOLS / SON 804 KAYAK AVENUE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State XXBurial 2 Cremation 3 Removal from State Department of Importent: If eny injury or one \* 4 ☐ Donation 5 ☐ Other (Specify) RESSURECTION CEMETERY 11/12/2005 CLINTON, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MARSHALL S FUNERAL HOME OF MARYLAND, INC. 4308 SUITLAND ROAD SUITLAND, MD 20746 nter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final H12 heimer's Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner death certificate be executed physician and the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai as IF FEMALE: esn 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy jo in the past 12 months? Month 4☐Pregnant at time of death Day Year 5 Other (specify) ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1□ Yes XX No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: XX Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home XSX Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c, Injury at Work? Certification: 28d. Describe how injury occurred the Hospital or Attending Injury XX Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 Hospital Sy/uste-SALVAdor State Registrar NOV 0 9

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year Physician November 02, 2005 3:54 **SMALLWOOD** KERRIE A. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Elkton Union Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1 M 2 KF 4, 1987 222-80-0139 WILMINGTON, DE Director Usual Residence of Decedent filed within 72 hours after death with the Marylend 10c. City, Town or Location 10d. Inside City Limits 10b. County or iteme 23a or 28a-f shov 1 ☐ Yes 2X No NEWARK Director DELAWARE NEW CASTLE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number UNITED STATES OF AMERICA 19702 106 HOLIDAY PLACE Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 1 end 2 should be filed within Health and Mental Hygiene. em 27 is marked other then ' College (1-4or 5+) Elementary/Secondary (0-12) RETAIL DEPARTMENT STORE 12 RETAIL SALES 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be DEBORAH A. SMALLWOOD ဥ RUSSELL BRANUM traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 end 2 s
Department of Health ar
Important: If Item 27 is
eny injury or other trau DEBORAH A. SMALLWOOD / MOTHER 106 HOLIDAY PLACE, NEWARK, DE 19702 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State GRACELAWN MEMORIAL PARK 11/11/2005 NEW CASTLE, DE 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee M00840 SPICER-MULLIKIN FUNERAL HOMES 1000 N. DUPONT PKWY., NEW CASTLE, DE 19720 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Multiple injuries /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physicien and I for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FFMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown sate has been signed by page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 🗆 No 1 Yes 2 🗆 No To the Hospital or Attending Physicien: 26. Place of Death (Check only one) 25. Was case referred to medical Be exeminer Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 2 No 1 Inpatient 28d. Describe how injury occurred subject in After thi funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day 28b. Time of Injury 27. Manner of Death Certification: motor vehicle collision Natural 5 Pending 3:00 PM 1 Yes 2 No death. 2 Accident 3 Suicide 11/2/05 investigation completely filled in by the I Director 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Route HD WB at the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours efter To the Funeral Dire molde line, ETKton, mD street 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number November 03, 2005 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hamela E. Southers, MI 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) NOV 1 0 2005 32. Registrar's Signatu State Registrar

		•	For State Registrar	State of M	arylan	d / Depa <i>Cer</i>	rtment of H tificate of L	ealth ai D <i>eath</i>		giene () () ( Reg. No.	5 37962
	Physicia /Medic		1. Decedent's Name (First, Middle, Las	"SHD	DLF	ER			2. Date of De Month	Day Y	3. Time of Death
	Examin		4a. Facility Name (If not institution, give Heartland Healt	h Care			4b. City, Town, or Hyatts	ville			e George's
	Funeral Director		5. Social Security Number  247-38-5512  Usual Residence of Decedent	ox 7. Ag □M 2QF	9e (In yrs. I	ast birthday) Yrs.	Months Days	Hours 24	Min. (Month, Da	ay, Year)	Birthplace (State or Foreign Country) South Carolina
	Maryland e-f show	ctor	10a. State 10b. County DC			Town or Loc Vashin					10d. Inside City Limits  YE Yes 2 □ No
	with the	i Director	10e. Street and Number 3108 Monroe St	reet. N.	Ε.		10f. Zip Code	200	18	10g. Citizen of Wh.	
336	72 hours after death with the Maryland naturel', or tems 23a or 28e-f show dreal Exempter nutt be notified at	by Funerai	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1  Yes 2 If Yes, Give Year or Dates:	Ever in U.		/as Decedent of Hi Yes, specify Cuba □ Yes 🏧 No		n? (Specify Yes or No Puerto Rican, etc.)	14. Race - Black,	American Indian, White, etc. Black
Maryland 21215-0036	within 9ne. then	Completed	15. Decedent's Ed (Specify only highest graves) Elementary/Secondary (0-12)		5+)	(Give I life. D	ent's Usual Occupa ind of work done of O NOT use retired utician	turina most c	of working	16b. Kind of Busin	ness/industry al Hygiene
nd 2	be filed ital Hygi id other event, I	Be	17. Father's Name (First, Middle, Last)						s Name (First, Middle	, Maiden Sumame)	
Aaryla	should and Men is marke aumatic	은	Clifton H. Bra	ype, Print)				and Number	lattie Le or Rural Route Numb reet, N.	er, City or Town, Sta	
nore, I	is 1 and 1 a		Jennie Foster -  20a. Method of Disposition  1	Removal from State	Cé	ace of Dispos emetery, crem	skingto ition (Name of atory or other place	9)	Date	20c. Location - Cit	C. I. HERVELLOW, AND COMPANIES
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licen.		Mt	22.	vet Cem Name and Addres 831 Geo	s of Facility	1/10/05 Latney's Ave NW;	Funera	t of Columbi 1 Home DC 20011
	Physician /Medical Examiner	ler	23a. Part. Enter the disease, or compshock, or heart fallure. List only of disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	a	a consequ	RENS	r the mode of dying			rrest,	Approximate Interval Between Onset and Death
98760,	requires that the death certificate be executed seen signed by the attending physician and hould be detached for use as the burial-transit	dical Examine	Cause, Disease or injury that initiated events resulting in death) Last	cDue to (or as	a consequ	ience of):					
P.O. Box 6	that the death certifice ed by the attending ph detached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 mooths? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal	death 3 🗆	Ectopic pregnancy Other (specify)			23d. Date of Month	•
	w requires that the state of speen signed by should be detact	þ	Part II. Other significant conditions of	MERS	200	NENT		on in Part I.			ite to the cause of death?
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Vita	Physician: Th this certificate rat director, pag	Be	25. Was case referred to medical examiner?  1  Yes 2  Vo	Hospital: 1 ☐ Inpatie	ent 2 🗆	ER/Outpatient	3□ DOA Othe		of Death (Check only of		(Specify)
ion of	Attending Physic death. ector: After this by the funeral di	ation; To	27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Inju (Month, Da		28b. Time of Injury	28c. Injury Work		28d. Describe	how injury occurred	-
Divis	i Dir	Certification;	3 Suicide 6 Could not be determined	28e. Place of Inj building, et	ury - At hor c. (Specify	me, farm, stre	et, factory, office		28f. Location (S City or Tox		or Rural Route Number,
	Mospital 24 hours a Funerel I etely filled	edical			f examinat				place, and due to the occurred at the time,		
	To the within 2 To the complet	Me	29b. Signature and title of certifier				29c. License	number		29d. Date signed (A	Month, Day, Year)
7	(5)		30. Name and address of person who d	completed cause of c	leath (Item	23a) (Type, F		005	8290	11/4	105
	Sta Registr		SORIEST KOUGR 31. Date filed (Month, Day, Year) NOV 1 0 200!	HJTTAI 32 Registr	R 4	203		ISBUT	27 RD 13	144TTSVI	LLE, My 2018/

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 15 Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 1, 2005 8:15 p DARLENE SALYERS <u>November</u> /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Days Funeral Months 1 ☐ M 2 🗓 F 78 Yrs Pennsylvania 28, 1927 Director 224-01-6405 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State in then "natural", or items 23a or 28a-f show the Modical Examiner is ust be notified at 1 Yes 2 No Completed by Funeral Director Prince George's Riverdale Maryland | 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20737 U.S.A. 4409 East West Highway Pages 1 and 2 should be filled within 72 hours after death nent of Health and Mental Hygene.
ant: If Item 27 is marked other than "natural, or Items 23 array or other traumatic event, if a Medical Examine mustary or other traumatic event, if a Medical Examine mustal. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black White etc. 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 🗓 No Specify Specify: White 3 ₩idowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 4 18. Mother's Name (First, Middle, Maiden Sumame) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be Sadie Collier Vincent Collier 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Raymond Collier - Brother 3005 Jamestown Road, Hyattsville, Maryland 20782 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Importent: If any injury or once. Fort Lincoln Cemetery 11/8/2005 Brentwood, Maryland 1 4 □ Donation 5 Other (Specify) 22. Name and Address of Facility Gasch's Funeral Home, P.A. 21. Signatur of Funer & Service Ucensee 4739 Baltimore Ave., Hyattsville, MD 20781 23a. Part. Enter the disease, or complications that caused the d-a.h. Do not enter the mode of dying, such as cardiac or respiratory arresphok, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disea + or condition resulting in death) Pnysician /Medical Due to (or as a cons-**Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a con Examine attending physician and for use as the burial-translt The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No Division of Vital Records, P.O. the 9□ Unknown detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. be 3 ☐ Probably 4 X Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate has 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 🔀 No ၉ this 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? Certification: After (Month, Day Year) 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Hospitel or Attending Physicien: after death. I Director: Af 24 hours a

within 2 To the To the

> 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KANSO, MD NASREEN

determined

and title of certifier

1005 ear)

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(Check only one)

29a. Certifier

29b. Signature

29c. License numbe

1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

#205, Takoma Park, MD 7610 Carroll Avenue,

State Registrar

Daniel Lee Shuler Jr. Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AJKG 1- State Registramend Item #1 Per ME G855 5/0 Partificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 5, 2005 **Physician** 11:30 A M SHULER, JR. SR. DANIEL LEE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring Montgomery Holy Cross Hospital If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1X M 2□ F WASH .. Director 579-86-5039 11-14-65 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State ir then "naturel", or iteme 23a or 28a-f ehow The Medical Examiner must be notitled at 1XYes 2 □ No Director SILVER SPRING MARYLAND MONTGOMERY 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 12359 HERRINGTON MANOR DRIVE 20904-1677 U. S. A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ lf Yes, Give Year or Dates: 3 ☐ Widowed 4 ☑ Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) FILE CLERK MEDICAL IMAGING HOLY CROSS HOSPITAL YEAR s 1 and 2 should be filed and Health and Mental Hygie item 27 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MYMIE LEE ASHFORD **ELISHA** SHULER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2503 BRENTWOOD RD., N. E. WASH., DC 20018 MYM1E LEE SHULER-MOTHER Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Itel any injury or oth 4 ☐ Donation 5 ☐ Other (Specify) HARMONY MEMO. PARK 11-15-05 LANDOVER, MD 22. Name and Address of Facility PINCKNEY-SPANGLER FUNERAL HOME 21. Signature of Funeral Service Licensee /hoodore 524 - 8TH STREET, N. E. WASHINGTON, DC 20002 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. not enter the mode of dying, such as cardiac or respiratory arrest, fmmediate Cause (Final disease or condition resulting in death) OF YORSO OUN SHOT **Physician** WOUND /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine transit death certificate be executed and Due to (or as a consequence of) burial-1 P.O. Box 68760, the attending physician lan/Medical the use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of defivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy ŏ Month Day Year Physic 4 Pregnant at time of death 5 Other (specify) ☐ Yes 2 ☐ No detached 9□ Unknown 9 Unknown signed by Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 1 🗌 Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1X Yes 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one) ¥QYes 2□No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Inpatient 2☐ ER/Outpatient 3☐ DOA this in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 5 Pending investigation 1 Natural SUBJECT SHOT death. 11/5/05 1 ☐ Yes 2 Alo 10:40 AM 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number of Rural Route Number, City or Town, State) SILVER STRING, 140 4 7 Homicide within 24 hours after To the Funeral Dire To the Funeral D HARRINGTON 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) November 6, 2005 O.C.M.E. 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) MP AMA 111 Penn Street, Baltimore, Maryland 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

NOV 1 0 2005

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month **Physician** Schoenwetter Howard 11:30 P M November 7, 2005 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Montgomery Shady Grove Adventist Hospital Rockville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Months Days Hours Min. Jan. 22, 1922 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sex 9. Birthplace (State or Foreign **Funeral** 1**√** M 2□ F Months 83 226-28-2384 Yrs. Iowa Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits r then "naturel", or iteme 23a or 28a-f ehow the Medical Examinar must be notified at Rockville Md. Montgomery 1 Yes 2 □ No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20850 USA 9805- Veirs Drive #2 death v Funeral 12. Was Decedent Ever in U.S. Amed Forces? 1 (X) Yes 2 □ No If Yes, Give 1 9 4 4 − 4 5 Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry filed within 72 Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Electrical Engineer Engineering 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Itam 27 is marked oth eny lighty or other traumatic event ang. 17. Father's Name (First, Middle, Last) Mary Ludeke George W. Schoenwetter 19a. Informant's Name/Relationship (Type, Pnnt) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9805- Veirs Dr., Rockville, Md. 20850 Marjorie Schoenwetter-Wife 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 XCremation 3 Removal from State Metropolitican Crematory-11/10/05-Alexandria, Va. 4 □ Donation 5 □ Other (Specify) 21. Signature of Fungral Service Licensee 22. Name and Address of Facility Hysong Co., Inc.

6510 16th Stroct N W Washington DC

Approximate Interval Batween Onset and Death 23a. Part1. Enter the disease, or com shock, or heart failure. List only Preumonia Immediate Cause (Final Physician Unknown disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner schoenwetter, Howard November 7, 2005 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) signed by the at d be detached fo 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ※ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? 2 2 No 1 ☐ Yes 2 ☐ No 1 Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Impatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury To the Hospital or Attendi within 24 hours after death. To the Funeral Director; A 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DCO62653 November 8, 2005 M.D. 30. Name and address experson who completed cause of death (Item 23a) (Type, Print) ROBBET RYAN HOLMES - 9901- MED, CENTER DR. ROCKVILLE MD 31. Date filed (Month, Day, Year) . Registrar's Signature State NOV 1 0 2005 Registrar

		•	For State Registrar	State	of Maryland		artment of H rtificate of l		Mental Hyg	giene ()	05	37966
1			Decedent's Name (First, Middle, L.	ast)					2. Date of Dea	ith Day	Year	3. Time of Death
	Physicia /Medic		Sylvia S	ingman					October	29,		8:59 A <sup>M</sup>
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		e .	Shady Grove Adv					ville If Under 24 Hr	6 0 D ( D)		lontgo	
	Funeral			Sex 1 M 2 F	7. Age (In yrs. I		Months Days	Hours Mir	. (Month, Da	n /, <i>Year)</i>	Cor	nplace (State or Foreign untry)
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-	land 10W		10a. State 10b. County		10c. City	, Town or Lo	cation					10d. Inside City Limits
2	Man	to	Maryland Montgo	mery	Roc	kville	9					1X Yes 2□No
4	in the	Director	10e. Street and Number				10f. Zip Code			10g. Citizen	of What Co	untry?
9	th will	<u>a</u>	299 Hurley Avenu	ıe			20850				5. A.	
1	within 72 hours after death with the Maryland liene. Then "natural", or Items 23e or 28e-f ehow the Madical Examinar must be notified at	Funeral	11. Marital Status	Armed F	cedent Ever in U.: forces? 2 (2)No	S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? ( in, Mexican, Pue	Specify Yes or No- erto Rican, etc.)	14.	Race - Amei Black, White	
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2-003p	hour tural		15. Decedent's	Year or I	Dates:	16a Dece	dent's Usual Occup	ation		16b Kind o	f Business/l	Industry
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7	within iene.	E	Elementary/Secondary (0-12)	College	(1-4or 5+)	Home	emaker			O	√n Hoπ	ne
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Mary	is 1 and 2 should of Health and Men Item 27 ie marke other traumatic		19a. Informant's Name/Relationship		1.*	19b. Maili	ng Address (Street	and Number or F	Rural Route Numbe	r, City or To	wn, State, Z	(ip Code) 20910
	and 2 ealth 1 27		Douglas R. Cogg	ıns – Gu	-			Road,				oring, Md.
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<u>a</u>	permit. Pages Department of I Important: If its any injury or o		21. Signature of Funeral Service Lice	ensee		Ď.	<sup>2. Name and Addres</sup> anzansky- 170 Rockv	Go Tacility Go Taber	g Memoria	1 Cha	pels,	Inc.
	20 = a	2 1	Donald (.	Xtol	theny	1	I/U Rockv	ille Pi	ke, Rockv	ille,	Maryl	Land 20852 Approximate
			23a, Part1. Enter the disease, or co shock, or heart failure. List on	by one cause on	each line.	1. Do not en	ter the mode or dyin	/ as cardi	ac or papiratory at	/ I St.		Interval Between Onset and Death
	Pnysician	4 1	Immediate Cause (Final disease or condition resulting in death)	_a. /s/c	-ute/	140	candit	1 fu	tranet	ov		Miviter
	/Medical Examiner		Todaling in doubly	Due to	o (or as a consequ	uence f):	10/00	$\Omega$ .	ScAle			Vacant
		-	Sequentially list conditions, if any, leading to immediate	b. Due to	o (or as a consequ	uen e of):	fel Ferri	y	1027/6			1000
	nsit	ul u	cause. Enter Underlying Cause (Disease or injury		6	100	Roma	1/2	Ilvne			YEARC
	execu n and al-tra	Examine	that initiated events resulting in death) Last	c. Due to	o (or as a consequ	uence of):	1 6 70	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
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	igned be d	by	Part II. Other significant conditions	s contributing to	death but not res	uiting in the L	inderlying cause giv	en in Part I.	238. Did t	obacco use		the cause of death?
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			1 - State Registrar	•	artment of Health and M rtificate of Death	lental Hygier Reg.	0000 2000
			Decedent's Name (First, Middle, Last)			2. Date of Death	3. Time of Death
	Physicia /Medic		Matlya Shilma	n		October 2	27, 2005 7:30P M
	Examin		4a. Facility Name (If not institution, give street and	number)	4b. City, Town, or Location of Death		4c. County of Deeth
			#2 Hartley Place		Gaithershurg		Montgomery
	Funeral		5. Social Security Number 6. Sex 1 □ M 2 ☑	F 89 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye May 25, 1	9. Birthplace (State or Foreign Country)
	Director	-	Usual Residence of Decedent	09 113.		May 25, 1	1916   Ukraine
	yland yland		10a. State 10b. County	10c. City, Town or Lo	ocation		10d. Inside City Limits
	Mar ified	to	Maryland Montgomery	Rockvi	11e		1 X Yes 2 No
	th the	Director	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Country?
	23a		5801 Nicholson Lane	#326	20852		ed States of America
21212-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "naturel", or Items 23a or 28e-1 show amportent: If Item 27 is marked other then "naturel", or Items 23a or 28e-1 show any injury or other treumatic event, Ite Medical Exam instruct the notified all page.	by Funeral	Arme 1 □ Never Married 2 □ Married 1 □ N	es 20 No	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 🛣No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: White
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7	athin nen	Completed		ge (1-4or 5+)	DO NOT use retired)		0 "
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ē,	# # # # # # # # # # # # # # # # # # #					Date 20c	: Location - City or Town, State
altimore,	Page nent countrible int: If		20a. Method of Disposition  1 ፟ Burial 2 ☐ Cremation 3 ☐ Removal (  4 ☐ Donation 5 ☐ Other (Specify)	rom State Parklawn Me	emorial Park 10/3	0/05 Ro	ckville, Maryland
Balti	permit. Departn Importe any inju		21. Signature of Funeral Service Licensee	Ed	Name and Address of Facility dward Sagel Funera 191 Rockville Pike		
	76		23a. Part1. Enter the disease, or complications t shock, or heart failure. List only one cause	hat caused the death. Do not ent			Approximate Interval Between
	Physician .		Immediate Cause (Final		Camainama		Onset and Death
	/Medical			1 Stage Biliary e to (or as a consequence of):	Carcinoma		
	Examiner		Sequentially list conditions b. And	emia due to the	e carcinoma		
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	cate be executed physician and the burial-transit	Examiner		structive Jaund: e to (or as a consequence of):	ice		
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Вох	ie death certificate be executed the attending physician and hed for use as the buriat-transit	Physician/M	in the past 12 months?		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
P. O.	law requires that the de as been signed by the a 2 should be detached f	Ph.	Part II. Dther significant conditions contributing	to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobaco	co use contribute to the cause of death?
ds,	uires tha signed Id be del	d by	Hypertension			1 🗆 Yes	2 XNo 3 Probably 4 Unknown
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<u>S</u>	Attending r death. ector: After by the fune	catic	2 Accident investigation		M 1 Yes 2 No		
Division	or Ati fter d jirect in by	Certification:	determined 286.	Place of Injury - At home, farm, strouilding, etc. (Specify)	reet, factory, office	28f. Location (Stree City or Town, S.	t and Number or Rural Route Number, itate)
<u></u>	pitel ours a erel [		29a. Certifier (Certifying Physician:	o the hest of the knowledge doct	h occurred at the time, date and place,	and due to the com-	e(c) and manner as stated
	To the Hospitel or Attendinition 24 hours after death.  To the Funerel Director: A completely filled in by the function	edical	(Check only 2 Medical Examiner: On	the basis of examination and/or in manner stated.	recoursed at the time, date and place, ivestigation, in my opinion, death occur	red at the time, date	and place, and due to the cause(s)
	To thi within To the	Me	29b. Signature and title of certifier	116	29c. License number	29d.	Date signed (Month, Day, Year)
}	7		1/1/		D46364		October 28, 2005
	V		30. Name and address of person was completed		Print)		
			Felix Borisovich Soko		25 Rockville Pike	<b>,</b> #203	Rockville, MD 20852
	Sta Regist		31. Date filed (Mohth, Day, Year)	32. Registrar's Signature	sele!		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Brigette Marie Thomas November 2, 2005 8:14 A. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Southern Maryland Hospital Clinton If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year)

March 10,1962 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2**X**) F 43 Director 214-86-1984 Maryland Usual Residence of Decedent death with the Maryland **ehow** 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other then "neturel", or Iteme 23a or 28a-f ehov other treumstic event, the Medical Examinar must be notified at 1 No 2 No Director Maryland Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3485 Breconridge Drive 20601 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 2 should be filed within 72 hours after a and Mental Hygiene. Is marked other then "neturel", or Iter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: **Black** ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Church Pastor Open Bible Ministries vears 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Robinson ٥ Charlie David Virginia Clayton 19a. Informant's Name/Relationship (Type, Print) (Husband) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s nent of Health an William Anthony Thomas, Jr. 3485 Breconridge Drive; Waldorf, Maryland 20601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Nov. 7, 2005 1 XBurial 2 Cremation 3 Removal from State Department of importent: If eny injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Washington National Cemetery Suitland, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
R. N. Horton Company Morticians, Inc.
600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Year Month Day 4 Pregnant at time of death 5 Other (specify) signed by the at id be detached fo 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed certificate 2 No 1 Yes or Attending Physicien: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ 16 2 ER/Outpatient ို 1 Inpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death Certification: 28d. Describe how injury occurred After 5 Pending investigation 1 Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 | Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only 29d. Date signed (Month, Day Year) 29b. Signature and title of certs 29c. License number mpleted cause of death/(Item, 23a) (Type, Print) 30. Name and address of ber

DHMH 17 Rev 1/2001

State

Registrar

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2. Registrar's Signature

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31. Date filed (Month, Day, Year)

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	/Media		ANITA LOUISE T						NOVEMB	ER 01, 20	05 11:00A <sup>M</sup>
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ιO.	or Itan	Fun	XX Never Married 2 Married	Armed Forces' 1 ☐ Yes XX If Yes, Give	?			can, Puerto	cify Yes or No- Rican, etc.)		hite, etc.
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21215-0036	within 72 hours after death with the Maryland ene. than "natural", or tiams 23a or 28a-f show I.a M. Jical Examili at must be mullind at	Completed	15. Decedent's (Specify only highest g	Education rade completed)	(Giv	edent's Usual C	done durina m	ost of worki	ng	16b. Kind of Busines	ss/Industry
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Maryland	2 should b and Ments is marked sumatic e		19a. Informant's Name/Relationship	(Type, Print)	19b. Mai	ling Address (S				r, City or Town, State	a, Zip Code)
	rt 2		LOUIE A. BLALOCK	/ BROTHER		5315 76		Е. НУ.	ATTSVIL	LE, MD 20	784
Baltimore,	0 0		20a. Method of Disposition  XX Burial 2 ☐ Cremation 3	☐Removal from State	20b. Place of Disp cemetery, cr	oosition (Name of ematory or othe	of r place)	D	ate	20c. Location - City	or Town, State
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Box 6	eath certific attending p	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					-	23d. Date of d	lelivery
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	the Ho hin 24 tha Fu npletel	Medical	one) 2 Medicel Exa	miner: On the basis o and manner sta	f examination and/or ii	nvestigation, in r	my opinion, de	eath occurre	d at the time, da	ate and place, and do	ue to the cause(s)
)	To To corr	~	29b. Signature and title of certifier	- auf		29c. Li	2162	7-3	29	ed. Date signed (Mor	oth, Day, Year)
A D	(5)		30. Name and address of person who	completed cause of d	leath (Item 23a) (Type	. Print)	^	· ·	Ever	0 -0	CROW Par
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		Ţ.	Decedent's Name (First, Middle, Last)					2. Date of De	ath Day	Year 3.	. Time of Death
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3	Funeral Director		5. Social Security Number 6. Sex 1 M	2 DXF 7. Age (In yrs. last b		Under 1 Year onths Days	Hours Mir		y, Year)	Country) Mary1	(State or Foreign Land
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9	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Items 23s or 28s-f show item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examinal must be notified at	y Funeral Director	11. Marital Status 12. 1 11. Married 2□ Married	Mas Decedent Ever in U.S. Armed Forces? I □ Yes 2 X No If Yes, Give Year or Dates:		Decedent of H s, specify Cuba Yes 2 X No		Specify Yes or No into Rican, etc.)	- 14. Ra Bla Speci	ice - American lack, White, etc.	
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R	(4)		30. Name and address of person who com	oleted cause of death (Item 23	3a) (Type, Prii	nt) 111	Penn St	reet Bal	timore,	, Maryla	and 21201
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	Registrar			Cei	rtificate of	Death		Reg. No.	2005	37971
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	ter death with the Maryland Items 23a or 28e-f show	Dire	10e. Street and Number			_	10f. Zip Code	0.50			en of What C	-	
	ns 23	Funerai	400 Christo	12. Was Deci	edent Ever in t			879 Hispanic Origin	? (Specify Yes or No-		U.S.A	erican Indian,	
٥	or iter		1 ☐ Never Married 2 🛣 Mar	ned 1 ☐ Yes If Yes, Gir	28 No		f Yes, specify Cub 1 ☐ Yes 2 ☐ No		? (Specify Yes or No- uerto Rican, etc.)	1	Black, Wh	ite, etc.	
2-003p	within 72 hours after ene. then "neturel", or ite	d by	3 ☐ Widowed 4 ☐ Divorced	Year or D	ates:						Specify: B		
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and	be file tal Hy d oth	Be	17. Father's Name (First, Middle,	Last)					Name (First, Middle,		Sumame)		
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Z	mit. Pages 1 and 2 should pertiment of Health and Mer portant: if item 27 is marke y injury or other treumatice.		19a. Informant's Name/Relations Mary Tyner	- Wife		400	Christ	and Number of .ooher	Ave #B G	r, <i>City</i> or Gait	Town, State, hersb	Zip Code) 20879 urq, MD	(
re,	of Health of Health filem 27		20a. Method of Disposition			Place of Dispo	sition (Name of natory or other pla	-				r Town, State	_
Ē	Pages ment of ant: # It		1X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5				rove Ce	· 1	L/11/05	Gai	thers	burg, MD	
saltimore,	permit. Depertrimports eny inj		21. Signature of Funeral Service	Licensee	1							Home P.A.	
4	48204		23a, Part 1. Enter the disease, o	r complications that	aused the dea	1					KVIII	e,MD20850	_
	hysician		23a. Part1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final	only one cause on e	each line.	4	~	. // .	- /		1	Interval Between Onset and Death	
	/Medical		disease or condition resulting in death)	a. Due to	(or as a conse	quence of):	1 your	2411	/ frek	726	nen	1 Timbes	
П	Examiner		Sequentially list conditions,	b	Con	020	my 10	Lite	my (	ise	De	rean.	<
	nsit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to	(or as a conse	quence of):			,				
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_ '		မ င်	25. Was case referred to medica	1				OC Diagonal	1 ☐ Yes	2 No	1 ☐ Yes	s 2 No	
<b>&gt;</b>	Physician: this certific ral director,	To B	examiner? 1 🗆 Yes 2 No	Hospital:	Inpatient 25	ER/Outpatien	t 3 DOA Ot	100	Death (Check only on g Home 5  Reside		□Other (Sp	acity)	
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	To the Nespital or Attending Prysician; within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Salc	29a. Certifier 1 Certifyii (Check only 2 Medical	ng Physician: To the	best of my kn	lowledge, death	occurred at the til	me, date and pl	ace, and due to the ca	ause(s) a	nd manner a	s stated.	_
	the H hin 24 the F uplete	Medicai	0110)	and man	ner stated.	ation and/or inv			ccurred at the time, d				
1	0 0		29b. Signature and title of certifie	6: 0	20	MI	29c. Licens	3 5 d	261	od. Date	signed (Moni	th. Day, Year)	101
	>		30. Name and address of person	who completed caus	se of death the	m 23a) (Type.	Print)	1) 1		/Y	DUP	1 1 CC	63
				7 000	1 Med	dical		Dr Roc	ckville,	MD	20850		
* 9	Sta Registr		William DO  31. Date filed (Month, Day, Year)	2005 RA	legistrar's Sign	ature	de						

State of Maryland / Department of Health and Mental Hygiene [] [] 5 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2005 Frank Michael Nov. 5:30 P M Vidotto /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2415 Kinderbrook Lane Prince George's Bowie If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Pay, Year)

Months Days Hours Min. July 10, 1938 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign \_\_Country) **Funeral** 1 XM 2 ☐ F Yrs. 578-48-5254 Wash., Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location wor 10d. Inside City Limits rthen "natural", or items 23a or 28a-f ehov the Medical Examiner must be notified at Director 1 Yes 2 □ No MD Prince George's Bowie 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 2415 Kinderbrook Lane 20715 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 XYes 2 ☐ No If Yes, Give 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White 2 3 Widowed 4 Divorced Year or Dates: 1954-55 Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Contractor Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mario Vidotto Elizabeth M. Todaro Antoinelli 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2415 Kinderbrook Lane Bowie, MD. Jo Ann Vidotto / spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Pages
Department of I
Important: If ite
eny injury or ot 1 Burial 2 Oremation 3 Removal from State Metropolitan Crematory 11/7/2005 Alexandria, VA. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Beall Funeral Home 21. Signature of Funeral Service Licenses 6512 NW Crain Hwy. Bowie, MD. Du 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Metastatic Lung Cancer 2 years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last as the burial-transi Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. attending physician Physician/Medical IF FEMALE. 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4 Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown s been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Chronic Obstructive Pulmonary Disease 1X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 🛣 No Other: 4 Nursing Home 5 Nasidence 6 Other (Specify) 2 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: Director: After 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide pelli within 24 hours a 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D47603 Nov. 7, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William DuBoyce, MD. 4000 Mitchellville Rd. # B-216 Bowie, MD. 31. Date filed (Month, Day, Year) Registrar's Signature. State Registrar NOV 0 8 2005

sicia		Decedent's Name (First, Middle		3 4 44			2. Date of Dea Month	Day	Year 3. Time o	Death
edica	al L	Betty	Sue	Wilson	4h City Town or	Location of Death	NOVEMBER	16 2 4c. County	2005 1035	141
mine	er '	a. Facility Name (If not institution		<i>91)</i>	CUMBER			ALLEC		
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ral tor		220-32-4346	1□M 2∏ F	81 Yrs.	Months Days	Hours Min.	Sep 6,	1924	Country)	
517	-	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside C	ity Limits
	.	MD Alleg			berland				¹k□Yes	2 🗆 No
	Director	10e, Street and Number			10f. Zip Code			Og. Citizen of V	What Country?	
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	Funeral	11. Marital Status	12. Was Decede Armed Force	ent Ever in U.S. 13	. Was Decedent of H If Yes, specify Cuba	ispanic Origin? (S In, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Rac Blac	ce - American Indian, ck, White, etc.	
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		19a. Informant's Name/Relations Frank Wilson			iling Address (Street		ral Route Numbe Cumbe		MD 2150	2
ì	1	20a. Method of Disposition		20b. Place of Disc	position (Name of		Date		- City or Town, State	
1		1 X Burial 2 Cremation		cemetery, cri	ematory or other place emorial Park	ce) .	11/19/2005			ID
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		23a. Part1 Enter the disease, or shook, or heart failure. List	r complications that cau	used the death. Do not e	inter the mode of dyir	ng, such as cardia	or respiratory ar	rest,	Approxima Interval Be	te tween
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State of Maryland / Department of Health and Mental Hygiene [] [] 5 1 = For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Walter Merrill Welch Nov 2005 5:43 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner La Plata
If Under 1 Year If Under 24 Hrs. Civista Medical Charles Co. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 1∭M 2□F Months Days Min Yrs. Director 230**-**36-7261 1928 Virginia Nov Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylar ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, Ina Medical Espirities must be roullised as 1 ☐ Yes ŽQNo Director Va. King George King George 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17518 Owens Landing 22485 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ☐ Yes 2 No f Yes, Give Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7; th and Mental Hygiene. ?7 is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) 4 Waterman Seafood 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Walter Welch Edna M. Owens 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22485 19a. Informant's Name/Relationship (Type, Print) 17518 Owens Landing, King George, Value of Disposition (Name of Date Date 20c. Location - City or Town, State Sandra J. Goerlitz/sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 2005 permit. Page Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Oakland Cem. King George, Va. Nov 21. Signature of Funeral Service Licensee 22. Name and Address of Facility m. To Nash & Slaw, King George, Va. 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of cying, such as cardiac or respiratory arrest, shock, or heart failure. Lib only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical as a consequence of) **Examiner** Sequentially list conditions, if any, leading to influediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner ng physician and as the burial-transit P.O. Box 68760 Physician/Medical attending IF FEMALE: 950 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred e Hospital or Attending P 24 hours after death. Funeral Director: After t Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0101035907 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. D. Boo Rosier Dedwylder Box 1359 , Dahlgren, Va. State NOV 07 2005 Registrar

2	<b>B</b>	1 - State Amend Item 18 Registrar  1. Decedent's Name (First, Middle, Last						2. Date of Deat	h	00	3. Time of Death
Physicia /Medic		SHIRLEY ELEAINE W						Novembe:	r 13,	2Ŏ <del>O</del> 5	11:34 Am
Examin		4a. Facility Name (If not institution, give Fort Washington Ho					Location of Death Shington			ity of Death	orge's
Funeral Director			х ] M 2 <b>X</b> F 7. Ag	e (In yrs. las 43	Yrs. If U	Inder 1 Year oths Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month Day JULY 24,1	962	9. Birthp	lace (State or Foreign LAND
pu »		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Location	)				1	0d. Inside City Limits
the Man 28a-f sh	Director	MARYLAND CHARLES  10e. Street and Number		LA PI		f. Zip Code		10	og. Citizen o	f What Coun	1 ☐ Yes 2 TNo
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Ind 21215-0036  be filed within 72 hours after death with the Maryland and the Hygiene. d other than "natural", or items 23s or 28s-f show event, it a Madical Examicar monthe notilised at	by Funeral	11. Marital Status  1 1 X Never Married 2	12. Was Decedent Armed Forces? 1 Yes 2 X If Yes, Give Year or Dates:			es 2 No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)		ace - Americ ack, White,	etc.
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Baltimore, permit. Pages 1a pepartment of Hes mportant: if tice my injury or othe ang.		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		сел	ce of Disposition netery, crematory UNIT CREM	or other plac	θ)	Date 2 BER 21, 200	Oc. Location  WALL	-	
Baltimore, Mippermit. Pages 1 and 2 Department of Health a Important: If tien 27 in any injury or other tra		21 LYDIA C. THORNTON	CHINSON MOO	_	THORN	TON FUNE	RAL HOME, I	P. A.			
Physician /Medical Examiner per pricial and physician and physician and physician and physician sit per physician and physician	icai Examiner	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as  Due to (or as  Due to (or as  Due to (or as	a consequei	nce of):		Deficienc	y byllaro			
Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be executed tuning the control by the tuneral Director. The training physician and telly filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal de	eath 3 □Ectop	oic pregnancy r (specify)				ate of deliver	ry Day Year
ds, Puires that signed bild be deta	ρ	Part II. Other significant conditions con	ntributing to death b	ut not resulti	ng in the underlyi	ing cause give	en in Part I.		acco use cor	ntribute to the	e cause of death?
Division of Vital Records, or Attending Physician: The law requires to after death.  Director: After this certificate has been signed in by the funeral director, page 2 should be control.	Completed	25 W.						127000	ed? No	Were autop prior to con death? 1 \( \sum \text{Yes} \)	sy findings available apletion of cause of
f Vita ysician: ysician: is certific director,	To Be	25. Was case referred to medical examiner? 1 X Yes 2 □ No	lospital: 1 ☐ Inpatie	ent 2. <b>X</b> EP	VOutpatient 3□	DOA Othe	_	h <i> Check onl</i> y one ome 5 ☐ Resider		her (Snecify	1
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Division  To the Hospital or Attendition 24 hours after death.  To the Funeral Director: At completely filled in by the fu	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubul	ury - At home c. (Specify)	e, farm, street, fa	ctory, office		28f. Location (Stre City or Town,	eet and Num State)	ber or Rural	Route Number,
the Hospit hin 24 hours the Funera npietely fille	edical (	29a. Certifier 1 ☐ Certifying Physical (Check only one) 2 ☑ Medical Examination (Check only one)	sician: To the best of ner: On the basis of and manner sta	examination	edge, death occur n and/or investiga	rred at the tim ition, in my of	e, date and place, pinion, death occurr	and due to the cau	use(s) and m	anner as sta , and due to	ited. the cause(s)
To the within To the comp	Me	29b. Signatore and title of certifier	n - (= - (	200	, hus	29c. License	number M.E.		d. Date signe Novemb		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2 3. Time of Death **Physician** NOVEMBER ŽÖ05 9:18 AM CHANDELL TYRONE WOOD /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner DOCTOR' PRINCE GEORGE'S HOSPITAL LANHAM If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ★ M 2 □ F 29 Yrs Director 220-02-3918 JUNE 6 1976 MARYLAND Usual Residence of Decedent with the Maryland 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 27 Is marked othar then "naturel", or itams 23a or 28a-f show treumstic event, the Medical Examinar must be notified at Director 1X Yes 2 No PRINCE GEORGE'S NEW CARROLLTON MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5314 85th AVENUE APT C-7 20784 U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No þ Specify. 3 Widowed 4 Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) None 12th None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 12 should ba fi and Mental F Is marked ot as 1 and 2 should be of Health and Menter item 27 is marked ပ GEORGE BROOK JOYCE WOOD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20784 JOYCE WOOD/MOTHER 5314 85th Avenue Apt C-7 NEW CARROLLTON, MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pagas 1 Department of H Important: If ite any injury or ot 1 Burial 2 Cremation 3 Removal from State 11/7/05 LINCOLN CEMETERY SUITLAND, MARYLAND `4 □ Donation 5 □ Other (Specify) 21. Signature of Coneral Service Licens 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Seizure Disorder with Complications Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Year Month Day 4 Pregnant at time of death 5 Other (specify) P.0. the 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 99 1 Yes 2 No 3 Probably 4 Unknown Discase Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed Division of Vital 2€ 1 ☐ Yes 2 🔀 No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2 No 1 Inpatient 2 ER/Outpatient Certification: To 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) 40051927 November 4. 30. Name and address of person whe completed cause of death (Item 23a) (Type, Print) 3001 SAVA DOV Sylv 31. Date filed (Month, Day, Year) Registrar's Signature State NOV 0 8 2005 Registrar

DHMH 17 Rev 1/2001

Registrar

NOV 0 8 2005

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			State of Maryland / Department of Health and Mental Hygiene  Certificate of Death
			Registrar Certificate of Death Reg. Mg. 000000
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	/Medic	al	Breit Heiton wooderr
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	Funeral		
	Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 15 Months Days Hours Min. (Month, Day, Year) 234–20–8704 84 Yrs. 84 Yrs. 84 Yrs. 85 Days Hours Min. (Month, Day, Year) West Virginia
	p .		Usual Residence of Decedent
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	28a-f	Director	Maryland     Anne Arundel     Crofton     ¹¾Yes 2 □ No       10e. Street and Number     10f. Zip Code     10g. Citizen of What Country?
	with Ba or		4263 Davidsonville Rd. 21114 USA
	ms 2:	era	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-
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2	filed Hygid other ant, I		12 AVIATION AIRCRAFT Mechanic US Navy  17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)
<u>a</u>	buld be Mental arked o	To Be	John Crawford Wooddell Hassie Mae Coberly
Maryland 21215-0036	2 should and Men is marks raumatic		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
	1 and 2 Health a Ism 27 is		Sandra M. Wooddell Willhite/ DTR. Main St. Hillsboro, West Virginia 24946
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Branchant: It item 27 is marked other than "natural; or thems 23a or 28a-f show many injury or other traumatic event, the Medical Examinat must be nutified at 90ce.		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or Town, State  West
Ē	Par Je Lin		'4 □ Donation 5 □ Other (Specity) Mountain View Cemetery 11-5-05 Marlinton, Virginia
Bal	permit. Pa Departmen Important: any injury once.		Beall Funeral Home
	10200		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate
	<b>5</b> 1		shock, or heart failure. List only one cause on eagh line.
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P.O. Box 68	at the by th tache	hys	9 ☐ Unknown
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ord	requii een s rould	ted	
ec	e 2 si	npie	Chronic obstructive pulmonary disease 24a. Was an autopsy findings available prior to completion of cause of death?
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<u> </u>	Phyaician: The faw this certificate has t al director, page 2 s	o Be	25. Was case referred to medical examiner?  1   Yes   2   No
0	ding Phyo n. After this funeral di	<b>—</b>	27. Marner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred
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Division of Vital Records,	J or Attano after deati Diractor: I in by the	Certification:	3 Suicide 4 Homicide  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Route Number, City or Town, State)
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	To the Hospital or Attanding within 24 hours after death.  To the Funerel Director: After completely filled in by the funer	edical	29a. Certifier  (Check only one)  (Check one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (
	ro the vithin of the comple	Me	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
}			128 on mp 10029571 11/02/05
R	-14/1V.		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
	0		Paul B. Berez, M.D. 1655 Crofton Blvd. #101 Crofton, MD. 21114
	Sta Registr		31. Date filed (Month, Day, Year)  NOV 0 8 2005

			1 - For State Registrer	State of M	aryland / Depa	artment o		Reg	g. No. LUU	37981
н	Physici	an	Decedent's Name (First, Middle, La.					2. Date of Death Month	Day Yea	
	/Media	cal	George W.			4h Chu Tour	m, or Location of Deat		30, 2005 4c. County of De	10:35A M
7	Examir	ier	4a. Facility Name (If not institution, given Montgomery Hospic		ev House)	Rocky		11		
	Funeral		5. Social Security Number 6. S		e (In yrs. last birthday)	If Under 1 Ye	ear If Under 24 Hrs		Montgom 9. B	ery lirthplace (State or Foreign Country)
	Director		Usual Residence of Decedent	<b>X</b> M 2□ F	80 Yrs.	Months Da	ys Hours Min.	March 19	, 1925 Wa	shington, DC
	be filed within 72 hours after death with the Maryland stal Hygiene. ed other then "neturel", or iteme 23a or 28s-f ehow event, the Madical Examinar must be notified at		10a. State 10b. County		10c. City, Town or Lo					10d. Inside City Limits
	Me Me Me	Funeral Director	Maryland Montgome	гу	Silver Sp					tx⊠xyes 2 □ No
	with the	吉	10e. Street and Number 3005 South Leisur	o World Ri	vd	10f. Zip Coo			g. Citizen of What ( United S	•
	leath	era	11. Marital Status	12. Was Decedent						nerican Indian,
(0	riten	臣	1 Never Married 2 Married	Armed Forces? 1 ☑ Yes 2 ☐ I	No 6/1/41		of Hispanic Origin? (S Cuban, Mexican, Puer	to Rican, etc.)	Black, WI	nite, etc.
8	rel', o	ğ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	6/9/43	1□Yes 2ሺ	No Specity:		Specity: B	lack
5-0	72 hc	Completed by	15. Decedent's Ed (Specify only highest gra		(Give	dent's Usual Oc	one during most of wo	rking	6b. Kind of Busines	ss/Industry
121	within ne.	m	Elementary/Secondary (0-12)	College (1-4or 5	i+)	DO NOT use re .ster	ntired)		D-1404	
9	filed Hygie ther		17. Father's Name (First, Middle, Last,		111111	ster	18. Mother's Na	me (First, Middle, Mi	Religion	
an	d be entai ked o	To Be	Calvin Wilson					Clegg	,	
Maryland 21215-0036	s 1 end 2 should be filed within 'f Heelth and Mental Hygiene. Item 27 ie marked other then "other treumatic event, the Mes	-	19a Informant's Name/Relationship ( Inez Lattimore/C			-	reet and Number or Rice St. NE;		•	•
a,	ges 1 end t of Heelth if item 27 or other to		20a. Method of Disposition		20b. Place of Dispo	osition (Name o	t !		Oc. Location - City	
Baltimore,	permit. Pages 'Department of Himportant: if its eny injury or ot once.		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif			matory or other oln Cem	etery Nov.	2, 2005	Brentwoo	d. MD.
慧	mit. F portar inju	1 3	21. Signature of Funeral Savice Lice				dress of Facility	ope Funer	al Homes	-,
ä	Depa Impo eny ii		) Cwa	XII	1108		Ī	538 Marlb orestvill	oro Pike	20747
	Physician /Medical Examiner and physician an	Examiner	23a. Part1. Enter the disease, or combody in the control of the co	a. Human Due to (or as Malign Due to (or as c.	Immunofefi a consequence of): ant Neopla a consequence of): a consequence of):	ciency				Inierval Between Onset and Death
8760,	ate be physicie the bur	Ical		d						
.O. Box 68	The law requires thet the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	⊒Ectopic pregna ⊒ Other (specify			23d. Date of d Month	lelivery Day Year
Ω.	thet the ded by deta	두	Part II. Other significant conditions of	ontributing to death b	ut not resulting in the u	inderlying cause	given in Part I.	23e. Did toba	cco use contribute	to the cause of death?
Records,	tuires n sign lid be	d by	Anemia					1 ☐ Yes	21☑No 3□	Probably 4 Unknown
00	w requ	Completed						24a. Was an	24b. Were	autopsy findings available
Be	The lav	Ë						autopsy	prior to death?	completion of cause of
Vital		BeC	25. Was case referred to medical				26. Place of De	1 ☐ Yes 25 ath Check only one	tr	es 2□No
<b>*</b>	× 5	ToB	examiner? 1 ☐ Yes 2 ⊠ No	Hospital: 1   Inpatie	nt 2 ☐ ER/Outpatier	nt 3 DOA	0#==	lome 5 ☐ Residen		pecify) Hospice
Division of	of lead	Certification:	27. Manner of Death  1. Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not b			М	njury at Work? 1 □ Yes 2 □ No	28d. Describe how	injury occurred	
Divi	itel or At	Certifi	4 Homicide determined	building, et				City or Town,	State)	Rural Route Number,
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fi	Medical	one)	ysicien: To the best niner: On the basis o and manner st	of my knowledge, deat f examination and/or in tted.	ivestigation, in n	ny opinion, death occu	irred at the time, dat	e and place, and d	ue to the cause(s)
<b>.</b>	To t Com	Σ	29b. Signature and little of certifler	1///		29c. Lic	ense number	290	d. Date signed (Mo	nth, Day, Year)
,		,	· Cell	111		- D'	11218		10/31/	05
R	(18) [1	a	30. Name and address of person who Charles Harrison	M.D. 600	1 Muncaste		Rd., Rockv	ille, MD.	20855	
1	Sta		31. Date filed (Month, Day, Year)		ar's Signature	10.0				

Rashaad Willie Jnknown 05-07324 ern

732	24		For State	State of Marylan		artment of H			iene 	5 37982
R	Physici	an	Registrar  1. Decedent's Name (First, Middle, Las  Paghood I	Ramel Robert W		tinoato or a	20411	2. Date of Deat Month	h Day Y	3. Time of Death
	/Medic Examin	al	Rasnaad F 4a. Facility Name (If not institution, give				Location of Death	October	4c. County of	005 12:55 A M
	Funeral Director		Johns Hopkins Hos 5. Social Security Number 6. Social Security Number 777–08–0108		last birthday) Yrs.	Baltin If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Dec. 31	Year)	9. Birthplace (State or Foreign Country) Washington, DC.
92	D D		Usual Residence of Decedent 10a. State 10b. County Maryland Montgome	10c. Cit	y, Town or Lo	cation er Spring		, Dec. 31	, 1702	10d. Inside City Limits 1X Yes 2 No
	with the a or 28s	Direc	10e. Street and Number  14311 Georgia Ave	nue #303		10f. Zip Code	20906		Og. Citizen of Wh	
3036	be filed within 72 hours after death with the Maryland hal Hygiene nd other than "naturel", or Itame 23a or 28a-f ehow event, the Modicel Expriner must be notified at	d by Funeral Director	11. Marital Status  1  Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 Yes 2 No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race Black, Specify:	- American Indian, White, etc. Black
1215-(	within 72 h iene. 'than "natu	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)		(Give lite.	dent's Usual Occup kind of work done of DO NOT use retired	during most of work I)		16b. Kind of Busi	onstruction
Maryland 21215-0036	should be filed ind Mental Hygis marked other umatic event, II	To Be C	17. Father's Name (First, Middle, Last) Reginald Rann				18. Mother's Nam	e (First, Middle, M Willie		
45	and 2 ealth a m 27 li		19a. Informant's Name/Relationship (Carol L. Willie-R 20a. Method of Disposition 1 Burial 2 Cremation 3	ann/Mother	14311 Place of Disponentery, cres	Georgia esition (Name of matory or other place	ce)	303; Sil	ver Spri 20c. Location - C	in, MD. 20906 in, MD. state Spring, MD.
Baltimore,	permit. Pages 1 Department of H Important: If ite any injury or otl once.		4 □ Donation 5 □ Other (Specification of Funeral Service Licer			Heaven Ce 2. Name and Addre	ss of Facility 11		wood Dri	ive
	Physician /Medical Examiner	Examiner	23a. Parl 1. Enter the disease, or com shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to introducte cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.  Due to (or as a consect.  Due to (or as a consect.  Due to (or as a consect.)	quence of):	ter the mode of dyir			est,	Approximate Interval Between Onset and Death
.O. Box 68760,	ne death certificate the attending phy: thed for use as the	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn 1 Live birth 2 Fets 4 Pregnant at time of (	aldeath 3	Ectopic pregnancy Other (specify)	1		23d. Date Mont	of delivery th Day Year
<u>α</u>	tuires that the signed by all be detacted	þ	Part II. Other significant conditions of	contributing to death but not re-	sulting in the s	inderlying cause giv	ren in Part I.	23e. Did tol		bute to the cause of death?  3 Probably 4 Unknown
Reco	The law requirete last been spage 2 should	Completed						24a. Was a autops perform	sy pr med? de	ere autopsy findings available for to completion of cause of eath?  Yes 2 \( \) No
of Vital Records,	Physicien: Th this certificete ral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death	28a, Date of Injury	ER/Outpatie	nt 3L DUA	ner: 4 🗌 Nursing Ho	th Check only on	30	
Division	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification;	1 Natural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not be 4 Metal Homicide determined	Blace of Injury At h			rk?  Yes 2⊠No	City or row	treet and Number n, State)	OF SUCT  OF RURAL ROUTE NUMBER,  AURO BALTINA
	To the Hospitel within 24 hours a To the Funeral Completely filled	Medical C	29a. Certifier 1 Certifying Pl	nysician: To the best of my kn miner: On the basis of examin and manner stated.	nwledne dea	th occurred at the travestigation, in my o	me, date and place opinion, death occur	and due to the c	ause(s) and man	ner as stated.
)	To the within 2 To the comple	Mec	29b. Signature and title of certifier	<b>*</b>	-	29c. Licens	o.C.M.E.		29d. Date signed	(Month, Day, Year) 31, 2005
R	(3)	ļ	30. Name and address of person who	10,40	11	. Print) 1 Penn St	treet, Ba			
-	St Regist	ate trar	31. Date filed (Month, Day, Year)  NOV 0 8 20	32 Registrar's Sign	ature do	ule				

Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Martel Huriana	) <u>=</u> e
		/sicia ledic amine
Division of Vital Records, P.O. Box 68760,	al or Attending Physicien: The law requires that the death certificate be executed enter chart.	s are to be a constituted by the attention of the attending physician and to linector: After this certificate has been signed by the attending physician and id in by the funeral director, page 2 should be detached for use as the burial-transit director.

	•	_ POI	partment of Health and N <i>ertificate of Death</i>	/lental Hygle Reg.		07000
		Decedent's Name (First, Middle, Last)		2. Date of Death	2000	3. Time of Death
Physicia		JERRY WIG	GINS	Month NOVEMBER	Day Year 5 2005	12:25 AM
/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	 1
		1617 ADDISON ROAD	FORESTVILLE		PRINCE	GEORGE'S
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye	1961 9. Birth	place (State or Foreign intry)
Director		578-96-4601 1™ 2□F 44 Yrs	Months Days Hours Min.	February	18 WASH	INGTON, DC
2		Usual Residence of Decedent				
show	_	10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits
88-f	cto		ESTVILLE			1  Yes 2  No
or 2	Director	10e. Street and Number	10f. Zip Code		Citizen of What Cou	untry?
death with the Maryland ms 23a or 28a-f show r must be notified at	rai	1617 ADDISON ROAD	20747		S.A.	
er de Items	Funeral		<ol> <li>Was Decedent of Hispanic Origin? (State of It Yes, specify Cuban, Mexican, Puerto</li> </ol>	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
o l	by F	1 🕅 Never Married 2 □ Married 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	1 ☐ Yes 2X No Specify:		Specify:	BLACK
nou ture	edit		cedent's Usual Occupation	161	b. Kind of Business/li	
n "na	Completed	(Specify only highest grade completed) (G	ive kind of work done during most of work b. DO NOT use retired)	ting	7. King of Dusinessin	ndustry
the.	mo	Elementary/Secondary (0-12) College (1-4or 5+)	CHEF		PRIVATE	
Hyg other	BeC	17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle, Mai	den Sumame)	
lid be lenta ked ic ev	ToB	LIONEL WIGGINS	JUANITA	SELMON		
shou and M mar umat	-	19a. Informant's Name/Relationship (Type, Print) 19b. Ma	ailing Address (Street and Number or Ru		ity or Town, State, Zi	ip Code)
alth a		LIONEL WIGGINS/FATHER 1210	06 BURCH VIEW DRIVE	CLINTON,	MARYLAND	20735
s 1 a if He item othe		cometen/	sposition (Name of rematory or other place)	Date 200	. Location - City or T	own, State
Page ento mr: if ryor		1 M Buriai 2 Cremation 3 Hemoval from State	Cemetery 11/8	/2005 I	ANDOVER, M	ARYLAND
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Butterly, or flems 23a or 28a-f show importent: If term 271s marked other then "naturely, or flems 23a or 28a-f show any injury or other treumatic event, Ire Modical Examinar must be notified at once.		21. Signature of Forest Johnson Licensee		. B. JENKI		
Deparim Important any ir			7474 LANDOVER ROAT			
		23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between
hysician <sup>*</sup>	ŝ		IMMUNODEFICIENCY S	YNDROME		Onset and Death
/Medical		resulting in death)  a. Due to (or as a consequence of):	TIMICHODEL FORESTOLE			
Examiner		Sequentially list conditions HUMAN IMMUNODEF	CIENCY SYNDROME VI	RAL INFEC	TION	
n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
rans	Examiner	that initiated events				
be executed ician and burial-transit		resulting in death) Last Due to (or as a consequence of):				
e ys	dicai	d				
ertific ding p	Physician/Med	IF FEMALE: 230 If yes, suiteems of grammary				
ath c attend for us	ian		3 Ectopic pregnancy		23d. Date of deliv Month	ery Day Year
he de the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 9 ☐ Unknown	5 Other (specify)			
that the ed by t detach		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	co use contribute to	the cause of death?
es be	d by	MYCOBACTERIUM AVIUUM INTRACELLULAR	PULMONARY INFECTION	I □ Yes	2□No 3□Pro	bably 4 🕅 Unknown
w requir been si should	Completed	PROGRESSIVE MULTIFOCAL LEUKOENCEPHAI	OPATHY	242 145	0.45 144	
has has ge 2	mp	TROCKEDSTVE HOLLET GOLD LETTERS		24a. Was an autopsy performed	prior to co	opsy findings available ompletion of cause of
		OF Was seen referred to medical		1 ☐ Yes 2 🛭	No 1 ☐ Yes	24 No
Physicien: The law r this certificate has tral director, page 2 s	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 № No	Othor	h (Check only one)	0.700	~ .
Phy this ald	<del> </del>	27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at	ome 5 Residence		ity)
Attending or death. ector: After by the fune	tion	1 XNatural 5 □ Pending (Month, Day Year) Injur 2 □ Accident investigation	y Work? M 1 ☐ Yes 2 ☐ No			
Atter r dea ector	ifice	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm,	street, factory, office	28f. Location (Stree		al Route Number,
s afte	Certification;	4 ☐ Homicide determined building, etc. (Specify)		City or Town, S	rate)	
ospit hours unere ly fille		29a. Certifier 1 Certifying Physician: To the best of my knowledge, de	eath occurred at the time, date and place,	and due to the cause	e(s) and manner as	stated.
To the Hospital or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the funer	Medicai	(Check only one)  2 Medical Exeminer: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occur	red at the time, date	and place, and due t	to the cause(s)
Veith To t	Σ	29b. Signature and title of certifier	29c. License number	1	Date signed (Month,	Day, Year)
		thered Illy Clynent	DC80+7	No	DUEMBIR	1, cecs
(3)		30. Name and address of person who completed cause of death (Item 23a) (Type	•			
		FRANCINE SHIPPMAN M.D. 11700 BE	LTSVILLE DRIVE # 10	0 BELTSVI	LLE, MARYL	AND 20705
Sta		31. Date filed (Month, Day, Year) 22. Registrar's Signature-				
Registr	aı	NOV 1 0 2005 Keeper A Age	- Charles			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 3,2005 **Physician** 11:47A November /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner DOCTORS COMMUNITY HOSPITAL LANHAM PRINCE GEORGE 5. Social Security Number 6. Sex Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1□M 2XF Months 578-30-1819 79 Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location or 28a-f show 10d. Inside City Limits or other traumatic event, the Medical Examinar must be notified at MD PRINCE GEORGE RIVERDALE Director Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5411 67th AVENUE Itama 23a permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "naturel", or Itama 23a eny injury or other traumatic event, the Medical Examinat must once. 20737 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Completed by Specify Specify: U.S.A. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th College (1-4or 5+) HOMEMAKER PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) FEAZELL LOFTON ROSE FEAZELL 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NEWTON RAY WILSON SR./HUSBAND 5411 67th AVENUE RIVERDALE, MD 20737 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ABurial 2 Cremation 3 Removal from State MD VETERANS CEMETERY 4 Donation 5 Other (Specify) 11-10-2005 CHELTENHAM, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JB JENKINS FINERAL HOME 7474 LANDOVER RD LANDOVER, MD 20785 23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on complications that caus Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine or Attending Physician: The law requires that the death certificate be executed burial-transit P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 3 ☐Ectopic pregnancy 2 Fetal death in the past 12 months? Month 4□Pregnant at time of death Day Year signed by the e 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate performe 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 🗌 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death After the 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Medical Certification: 28d. Describe how injury occurred 5 Pending investigation Injury death. I Director: , 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Direct 4 Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) death (Item 23a) (Type, HUN TUNG

State Registrar DHMH 17 Rev 1/2001

Wilson, Thelma

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

					Olale 0	i iviai yia	•	tificate of		т мептат ну	0.0	0.5	0 7 0 0 5
			1. Decedent's Nam	e (First, Middle	, Last)		061	incate of	Dealli	2. Date of De	Reg. No:	UD	3. Time of Death
	Physicia									Month	Day	Year	
-	/Medic Examin		4a Fecility Neme (i	cothy Di	eane Will aive street end nu	iams mber)			4b. City, Town, o	or Location of Deet	08 h 4c Count	05 ty of Death	2:25 AM
4		e:				_			T	1			
	Funeral		5. Social Security N		n Hospita 6.Sex		lest birthdey)	If Under 1 Year		Shington rs. 8. Date of Bir	th Pr		Georges
и	Director		225 16 6	0.72	1□M 2∏F	8.	"	Months Days	Hours Mi			1	place (State or Foreign
			325-16-8 Usuel Residence of	Decedent						12-04	-19		IL.
	how how		10a. Stete	10b. County		10c. C	ity, Town or Lo	cation				1	0d. Inside City Limits
	a Ma	용	MD	Cha	rles	Ţ	White P	lains					1  Yes 2 □ No
	₹ 22 B	S	10e. Street end Nur	mber				10f. Zip Code			10g. Citizen of	What Cour	itry?
	23a	ē	4324 Ca	stle To	wer Court			20695			United	l Stat	es
	r dag	an l	11. Maritel Status		12. Wes Dece Armed Fo	edent Ever in Urces?	J,S. 13. V	Vas Decedent of H	lispenic Origin? an, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	)- 14. Ra	ce - Americ	
20	s afte	Y	1 Never Merri		If Yes, Giv	10		□Yes 257No		,	Specia		010.
21215-0020	filad within 72 hours after daath with the Maryland Hygiana. the than "natural", or items 23a or 28e-f ehow ent, the Medical Examinat must be notified at	Completed by Funeral Director	3 X Widowed		Yeer or D	ates:						Bla	
5	27 n	ete	(Spec	15. Decedent' ify only highes	grede completed)		16e. Deced	ent's Usual Occup kind of work done OO NOT use retire	during most of w	vorking	16b. Kind of E	lusiness/Inc	fustry
12	with ana.	Ē	Elementery/Seco	ndary (0-12)	College (1	-4or 5+)					T- 1	1 0	
D	filad Hygi ther mt,	ပ္	17. Fether's Neme	(First, Middle, L	ast)		Accou	ntant Te		Π ame <i>(Fir</i> st, <i>Middle</i> ,			vernment
Maryland	d ta b	To Be								llie Mack		,	
N.	2 should and Man Is marka	F	19e. Informent's Na	Billin me/Relationsh			19b Mailin	n Address (Street		Rurel Route Number		State Zin	Cade
Ž	and 2 aught ar n 27 is	i			ants/Daug	ther	1	ox 523		Plains, N			0000)
ē,	1 and Haalth tam 27 other tr	ŀ	20a. Method of Disp		ancs, baug	20b.		ition (Name of etory or other place		Date	20c. Location		wn. State
9	Pagas nant of h int: if its		1 ☐ Burial 2 ☐ 4 ☐ Don <i>e</i> tion	Cremation	3 ဩRemoval from \$	State		Cemeter		11-14-05			
Baltimore,	보험한글		21. Signature of u		^	1		Name and Addre	ce of Engility	1			
ñ	Depa Impo any I		121	//		-10	11/		235	Stricklan			
		-	23a Perti Enter th	e disease or	complication also that or	aused the dea				oad, Camp		,s, MD	
-	Physician		shock, or hear	rt failure. List o	complic in Tis thet can be one cause on e	ech line.	in. Do not one	tille mode of dyll	ig, socii as caidi	ac or respiratory as	ilest,		Approximate Interval Between Onset and Death
1	/Medical		Immediate Ceuse (	Final			1					1	
	Examiner		disease or condition resulting in death)	П	a	Dueto	or as a consequ	ience off:				1	
		ner			C	le ron	S	9/1/4/	Dec	- 5. Fus	Wee		
	The law raquiras that the death cardificate be axecuted at has been signed by the attending physician and page 2 should be detached for use as the buriel-transit	Examiner	Sequentially list cor	nditions,	b	Due to (	or es a consequ						
ó,	e axe ian a unal-	Ě	Sequentially list cor if any, leading to im cause. Enter Under Ceuse (Disease or that initiated events	mediate rtying									
68760,	ata b hysic tha b	edicai	that initiated events resulting in death) L	ast	С	Due to (c	or es e consequ	ence of):					
9 x	antific ding p	Ž			d							i	
Вох	aath cart attandin I for usa	Physician/M			u								
o	tha a	ysic	Part II. Other signifi	cant condition	s contributing to de	ath but not res	ulting in the un	derlying cause giv	en in Part t.	23b. Did t	obacco use co	ntribute to	the cause of death?
P.0	that tha da		it	200+	Como ich.	sun				10'	Yes 2□ No	3 🗆 Prob	ably 4 Unknown
Vital Records,	uiras t signa Id ba	ğ			0	/	,					045 141-	the state of
Ö	w raqu baan should	Completed		lee 1	ing de	7 ste	net.	m.			an autopsy med?	ava	re autopsy findings ilable prior to roletion of cause
360	a law has l	립			Ø)						_		eeth?
										1 🗆 Y	res 28 No	1 🗆	Yes 2□ No
<u> </u>	<u> </u>	20	25. Was case referrence exeminer?	~	Hospital:		-	Oth		eath (Check only o			
ō	hys his	0	1 ☐ Yes 2 ☐ A 27. Manner of Death		28a. Date o		ER/Outpetient		4 Li Nursing	Home 5 ☐ Resid			)
5	ttending Phy death. :tor: After thi	<u> </u>	Natural	5 Pending	(Month	n, Day Year)	28b. Time of Injury	28c. Injun Worl M 1 □	k?	28d. Describe h	iow injury occur	rea	
isi	Attending in death.  ector: After by the fune	Sal	2 ☐ Accident 3 ☐ Suicide	investige 6 ☐ Could no	t be	of Injuny . At h	ome farm etra	et, factory, office	Yes 2 □ No	28f. Location (S	traat and Numb	nor or Pural	Pouto Mumbar
	Direction of A	Certification:	4 Homicide	determin	buildin	g, etc. (Specif	y)	st, ractory, office		City or Tow	m, Stete)	er or norar	Hobie Number,
_	To the Hoepital or Attenwithin 24 hours aftar deat To the Funeral Director: complataly filled in by tha	2	29a. Certifier	Certifying	Physician: To the t	est of my kno	wledge, death	occurred at the tim	e, date and place	e, and due to the o	ause(s) and me	anner ac et	ited
	Ho Ho	edicai	(Check only one)	2 Medical E	caminer: On the ba	sis of examina	tion and/or inve	stigation, in my or	oinion, death occ	urred at the time, o	date and place,	and due to	the cause(s)
	Verithing to the comp		29b. Signature and t	itle of certifier				29c. License	number	2	29d. Date signe	d (Month, E	Pay, Year)
	-		<	- Copy	1			04:	2755		No	1 8.	2005
0	(8)		30. Name end eddre	ss of person				rint)	depr	Potter	Jr.		
K	- 6	_	10	301	THU	Jesh.	ngton	Rd.	H	Wesh.	- Ston	. M.	2005
	State	e	31. Dete fited (Month	n, Day, Year)		gistrer's Signa	Gibt	20					

			1 - For Stete Registrar				nd / Depa	artment of I	Health ar		•	e	3798	6
	Diam'r.		1. Decedent's Name (First, Mid	dle, Last)							ate of Death		3. Time of Deal	th
	Physici /Medio		William Dex	er W	hite						vember	04,2005	5:00 P.	М
E.	Examir	er	4a. Facility Name (If not instituti	-				4b. City, Town,	or Location of I	Death	4	c. County of Dea	th	
			Prince George 5. Social Security Number	e's H	ospital	Cent	er	Chev If Under 1 Year	rerly If Under 24	Hre la D	Pr	ince Geo	orge's	
	Funeral Director		220-70-4373 Usual Residence of Decedent		M 2□F	48	. last birthday) Yrs.	Months Days		Min. 3/	ate of Birth Ionth, Pay Year 27/57	)   Co	hplace (State or For buntry) 1.,D.C.	eign
	yland sow		10a. State 10b. Coun	ry		10c. C	ity, Town or Lo	cation					10d. Inside City Lin	nits
	Mar Mar	tor	Md. P.G.				Temple	Hills					1 <b>X</b> Yes 2 □	No
	or 28	lre	10e. Street and Number					10f. Zip Code			10g. C	itizen of What Co	ountry?	
	ath w 23a	<b>Funeral Director</b>	3138 Brinkle	∍у Ro	ad # T-	.3		2074	:8			U.S.A.		
	er des	une	11. Marital Status		<ol><li>Was Decede Armed Force</li></ol>	es?	U.S. 13. \	Was Decedent of I f Yes, specify Cub	Hispanic Origin an, Mexican, F	n? (Specify Y Puerto Rican,	es or No- etc.)	14. Race - Ame Black, Whit	ncan Indian, e, etc.	
36	rs aft	by F	1 ☐ Never Married 2 ☑ Ma 3 ☐ Widowed 4 ☐ Divorce	1	1 ☐ Yes 2 If Yes, Give Year or Date			1 ☐ Yes 2 🔀 No	Specify:			Specify: Bl	.ack	
21215-0036	72 hours after death with the Maryland netural', or Itams 23a or 28e-1 show dical Examinat must be notified at	ted	15, Decede	ent's Educ	ation		16a, Deced	dent's Usual Occur	oation		16b. 8	Kind of Business/	Industry	
215	within 7. ene. then "n	ple	(Specify only high Elementary/Secondary (0-12)	Ť	Completed) College (1-4	or 5+)	(Give	kind of work done DO NOT use retire	during most o d)	f working			,	
2	e filed within al Hygiene. other then '	Completed	12th				Disa	bled	,		No	ne		
nd	0 5 0	Be	17. Father's Name (First, Middle	, Last)							, Middle, Maide	n Sumame)		
3	should be ind Mental marked ( umatic ev	<sup>2</sup>	William White								Gordon			
Maryland	s 1 and 2 should f Health and Men item 27 is marke other treumatic		19a. Informant's Name/Relation					ng Address (Street Brinkley						
	s 1 an of Heall item 2 other		20a. Method of Disposition			20b.		sition (Name of natory or other pla		Date		ocation - City or		-
Baltimore,	permit. Pages Department of Important: If it any injury or o		1X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other		moval from Sta	מומ			1	1 /12 /0				
<b>≣</b>	mit. F partm portar rinjur		21. Signature of Funeral Service		•		22	Mem. Par . Name and Addre	ess of Facility	1/12/0		ndover,		_
ä	Depa Impo any ii		any	W.	C) a	4	1 H	l S Washi 925 Burr	ngton & oughs A	& Sons	Co. Inc	ington	D.C.20019	
	Fnysician /Medical		23a. Part1. Enter the disease, shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	or complices to only one	_ Cereb	ral I	nfarcti	er the mode of dyi	ng, such as ca	rdiac or resp	iratory arrest,		Approximate Interval Between Onset and Death	
	Examiner .	er	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	b.	Cereb		emmorha	ge						
,	icate be executed physician and s the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c.	Hyper Due to (or	tensio								
8760,	ysicia ne buri	cat		d.	Renal	Fail	ire							
9	artifica ing ph e as th		IF FEMALE:	1										
P.O. Box	that the death certificate led by the attending phys detached for use as the	Physiclan/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23	c. If yes, outcor 1□Live birth 4□Pregnan 9□Unknow	n 2 ☐ Fet tat time of	al death 3	Ectopic pregnanc Other (s <i>pecify)</i>	/			23d. Date of deli Month	very Day Year	
	iaw requires that the as been signed by th 2 should be detache	by Pr	Part II. Other significant condi	ions cont	ributing to deat	h but not re	sulting in the ur	iderlying cause giv	en in Part I.	23	3e. Did tobacco	use contribute to	the cause of death?	,
Vital Records,	w require been sign should b									_	1 Yes 2	□No 3□Pro	bably 4 Unkno	wn
ec	e iaw r has be je 2 sh	Completed								24	a. Was an autopsy	prior to c	topsy findings availa	
严	Th ate pag	Con								18	performed? ∃Yes 2 <b>2.</b> No	death?	2□ No	
Vit:	icien certifi rector	Be	25. Was case referred to medic examiner?		spital:			Oth		Death (Chec				
ō	Attending Physicien: The la r death, ector: After this certificate has by the funeral director, page 2	70	1 ☐ Yes 2 🛣 No 27. Manner of Death	1	1 primpa		ER/Outpatient 28b. Time of	28c. Injur	4 LI Nursii		Residence	6 ☐Other (Spec	ufy)	_
on	th. : Afte	tlor	1 Natural 5 Pend	ing tigation	28a. Date of li (Month, i	Day Year)	Injury	Wor	k? Yes 2 ☐ No		osciloo now inju	ry occurred		
Division	I or Atter after dea Director i in by the	Certification:	3 ☐ Suicide 6 ☐ Could	not be mined	28e. Place of building,	Injury - At h etc. (Speci	nome, farm, stre fy)	eet, factory, office			cation (Street ar ty or Town, State		ral Route Number,	
	To the Hospitel or Attending I within 24 hours after death.  To the Funerel Director: After completely filled in by the funerel	edical C	29a. Certifier 1 Certify (Check only one)	ng Physic I Exemine	cian: To the be er: On the basis and manner	s or examin	owledge, death ation and/or inv	occurred at the tir estigation, in my o	ne, date and p pinion, death o	place, and due occurred at th	e to the cause(s ne time, date and	) and manner as d place, and due	stated. to the cause(s)	
	To the within 2 To the complet	Me	29b. Signature and title of certifi	er /				29c. Licens	e number		29d. Da	te signed (Month	Day, Year)	
}	1		1/ land	en	-			0	3031	5	11	10/0		
2	and		30. N e and dress of person	1 who com	pleted cause o	of death (Ite	m 23a) (Type, F	Print)			1		4	
			James Cata	<i>r</i> enis	,M.D. 3	8001 н	ospital	Drive,	Chever	Md.	20785			
3	Sta Registr	4.3	James Catar 31 Date filed (Month, Day, Yea NOV 0 8	2005	. Regi	strar's Sign	ature	le '		-1 (				

		State of Maryland / Department of Health and M  State Registrar  State Of Maryland / Department of Health and M  Certificate of Death		iene () (	)5	3798	37
Physicia /Medica		1. Decedent's Name (First, Middle, Last) De Alva Wheeless	2. Date of Death Novembe	r <sup>D</sup> 3, 2	0 <del>05</del> ′	3. Time of D 2:27P	eath M
Examine		4a. Facility Name (If not institution, give street and number) Shanthi Home  4b. City, Town, or Location of Death Laurel		4c. Count Prin	of Death Ce Ge	orge's	
Funeral Director		5. Social Security Number 6. Sex 1 Days 1 Da	8. Date of Birth Month Day, April 3	, 1916	9. Birthp Cour Texa:	lace (State or i itry) S	Foreign
Maryland f show		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  Maryland Prince George's Hyattsville			1	0d. Inside City	
with the 3a or 28e-	Funeral Director	10e. Street and Number 3420 Purdue Street 20783-1911	10 U	g. Citizen of Inited	What Cour State	itry?	
urs after death	2	11. Marital Status  12. Was Decedent Ever in U.S.  Armed Forces?  1	ecify Yes or No- Rican, etc.)		ce - Americ ck, White,		
Maryiailid A I A I D-0030 d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 77 is marked other then "naturel", or items 23a or 28e-f show treumatic event, Ire Madical Examinar must be nutified at	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0212)  College (1-4or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of workii) life. DO NOT use retired)  Secretary	ng 1	6b. Kind of B		<sub>dustry</sub> ep <b>r</b> esen	ativ
Id be file fental Hygurked other tic event,	lo Be C	17. Father's Name (First, Middle, Last) William Wiley Wheeless Fmily Pe	e (First Middle, Mar Mar Mar	laiden Sumar TIN	ne)		
ind 2 shot alth and N		19a. Informant's Name/Relationship (Type, Print)  Louise W. Wheeless -sisterinlaw 3420 Purdue Street Hya	A Route Number,	City or Town,  Mary	State, Zip Land	<sup>Code)</sup> 20783	
Dartimore, Marylar Permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked eny injury or other treumatic ex ance.		20a. Method of Disposition  1 Deurial 2 Cremation 3 Removal from State  1 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Gate of Heaven Cemetery 11/		oc. Location	-		and
Dalli permit. Departri Importa eny inju		21. Signature of Funeral Service Litenske  22. Name and Address of Facility and Lonald V. Borgwardt 4400 Powder Mill Roa	Funeral	Home,	PA Marv	land207	05
Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Cerebral Infarct  Due to (or as a consequence of):	r respiratory arre	st,	2	Approximate Interval Betwe Onset and De WECKS	en ath
ficate be executed they be seen and sthe burial-transit	uicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disasse or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):					
the death certii	Me.	IF FEMALE:  23b. Was decedent pregnant in the past 12-months?  1			te of delive	ry Day Yea	ar
quires that n signed build be deta	you ]	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension; Coronary Artery Disease	23e. Did toba	5.7		e cause of dea	
	combiered		24a. Was an autopsy perform	ed?	Were autoporior to condeath?	esy findings avanpletion of cause	allable se of
F F Sign F	2	f Natural 5 ☐ Pending (Month, Day Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No		ice 6 HOth		sted L	ivin.
tel or Attending P rs after death. el Director: After ted in by the funera		3 ☐ Suicide 4 ☐ Homicide  Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	8f. Location (Stre City or Town,		er or Rural	Route Numbe	r,
To the Hospitel or within 24 hours aft. To the Funerel Di completely filled in	מחוכש	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	nd due to the cau od at the time, dat	ise(s) and ma e and place, a	nner as sta and due to	ited. the cause(s)	
To the within To the Comp	E .	29b. Signature and title of certifier  D23181	29 <u>0</u>	d. Date signed IOVEMDE	r 4,	2005	
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rajkumar Bhojraj, MD 704 Gorman Avenue, #T1 Laurel, Mar	yland 20	707			
State Registrar		31. Date filed (Month, Day, Year)  NOV 0 8 2005					

			1 - For State Registrar	State of Ma	ryland			nt of H		nd Me	-	giene	05	379	88
ľ	Physici /Medi		1. Decedent's Name (First, Middle, La Guillermo Zariqu	,							2. Date of De. Month Novembe	Day	Year 2005	3. Time of 12:10	1.4
	Examir		4a. Fecility Name (If not institution, giv		• • •				Location of			4c. Cour	nty of Dea	th	, p.i
	Funeral		Shady Grove Adve 5. Social Security Number 6. S			st birthday)	If Unde	kvill r1Year	If Under 2	4 Hrs.   8	B. Date of Birt (Month, Da		gomer	<del>-</del>	r Foreian
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Director		NONE Usual Residence of Decedent	<b>X</b> M 2 □ F	68	Yrs.	Months	Days	Hours	Min.	(Month, Da	v, Year) L, 1936	6 Pe	thplace (State of ountry) : <b>Tu</b>	, roreign
	Maryland a-f ehow	tor	10a. State 10b. County  Maryland Montgome			Town or Lo								10d. Inside Ci	1
	or 28	Directo	10e. Street and Number		04101			p Code				10g. Citizen o	of What Co	ountry?	
	eath w	erai	9005 Green Run W					879				Peru			
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23e or 28e-f ehow among rightly or other treumatic event. The Modical Examinant must be notified at once.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 Tyes 2 No If Yes, Give Year or Dates:		l I	Was Dece f Yes, spe I⊠ Yes		Specify:	in? (Spec Puerto Ri Peruv	ify Yes or No- ican, etc.)	14. R 8	lack, Whit		
5-0	72 ho	eted	15. Decedent's Ed (Specify only highest gra	fucation de completed)		16a. Deced	lent's Usu	al Occupa				16b. Kind of			
12	within ene. than '	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	-)	life. L	DO NOT I	se retired) ficer				D	• - 37		
2	Hygin other	C	17. Father's Name (First, Middle, Last)			Nava.	I OI			's Name (	First, Middle,	Peruvi		avy	
<u>/lar</u>	Menta Menta arked	To B	Mauel Zariquiey						Dora				,		
Jan	l 2 sho n and ls ma reum		19a. Informant's Name/Relationship (7	•		19b. Mailin	g Addres	s (Street a	nd Number	or Rural I	Route Numbe	r, City or Tow	n, State, Z	Zip Code)	
	1 and Healtl tem 2		Matilde Zariquie  20a. Method of Disposition	y (Wife)	20b. Plac	9005 se of Dispos	Gree	en Ru	n Way	, Gai		ourg, M			
Ē	Pages ent of nt: If If		1 ☐ Burial 2 【Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			ce of Dispos netery, crem							•	Virgin	ni o
Baltimore,	permit. Departm Importa any inju		21. Signature of Funeral Service Licen		Heti	22	Name a	nd Address		DeVo	1 Fune	ral Ho		virgi	IIa
華			23a Part1. Enter the disease or companies or companies or beart failure. List only	plications that caused to	he death.	Do not ente	or the mo	de of dying	, such as ca	ardiac or r	espiratory ari	est,		Approximate Interval Bety	9
e suite	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Acute My	ocard	lial I	nfar	c <b>ti</b> or	1					Onset and D	eath (
7.7	/Medical Examiner		Tosailing in dealing	Due to (or as a	conseque	nce of):									
4		Jer	Sequentially list conditions, a.y. back gradient cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a	conseque	new off;									
	cate be executed bhysician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c											
8760,	be ex ician a burial	icai Ex	resulting in Ceatify Last	Due to (or as a	consequer	nce of):									
687	flicate p phys	ba		d											
O. Box	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1□Live birth 2 4□Pregnant at tii 9□Unknown	☐Fetal de	eath 3 🗆	Ectopic p Other (s <sub>t</sub>	regnancy Decify)					ate of deli-	-	ear
J.	res that the de signed by the a be detached f		Part II. Other significant conditions co	ontributing to death but	not resultin	ng in the un	derlying o	auca awa	in Part I		23a Did to	22000 1150 000	niebuta ta	the cause of de	
ords,	w requires been sign should be	Ω										es 2 🔀 No		bably 4 DU	
r	The larete has	Completed								_	24a. Was a autops perform	ned?	Were aut prior to codeath?	topsy findings a ompletion of ca 2 \(\text{\text{\text{No}}}\)	vailable use of
<b>X</b>	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 🔀 Inpatient	٥П٥٥	10		1 04-			Check only on				
ō	ding Phys h. After this funeral di	-	27. Manner of Death	28a. Date of Injury (Month, Day)		Outpatient  D. Time of		8c. Injury	4 🗀 Nuisi			once 6 Ot		ufy)	
200	endin eath. or: Aft he fur	atio	1 Natural 5 Pending 2 Accident investigation	10	(ear)	Injury	М		s 2 □No	,					
DIVISION	To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	building, etc.	(Specify)						City or Town	i, State)		ral Route Numb	99 <i>r</i> ,
	Hosp 24 hou Fune etely fi	edical	29a. Certifier (Check and) (Check and) 2	rsician: To the best of iner. On the basis of each manner state	xammation	idge, death i and/or inve	occurred estigation	at the time , in my opii	, date and p nion, death	place, and occurred	I due to the ca at the time, d	ause(s) and mate and place,	anner as : and due	stated. to the cause(s)	
	Within To the compl.		29b. Signature and title of certifier	A				: License		<del> </del>		9d. Date signe			
	4		1 -7/10	<u> </u>			1)	1A 40	2649	5900		Novemb		,	
			30. Name and address of person who c				rint) De	niel	Gold	erg,	M.D.		O1 0,	, 2005	
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			1 - For State Registrar	State of Maryla	nd / Depa <i>Cei</i>	artment rtificate	t of He	alth a leath	nd M		giene (	)5	37989
	Physic	ian	1. Decedent's Name (First, Middle, La	•						2. Date of Dea	_	Vear	3. Time of Death
1	/Medi		Addie Pearl B							11 Month	1 <sup>Day</sup> 2	2005	12:36 AM
	Examir	ner	4a Facility Name (If not institution, given Southern Mary 1	and Hospita.	1	Cli	rown, or Lo nton	ocalion ol	Death		4c. Count Prin	y ol Dear LCE	deorge's
	Funeral Director		257-18-8669	ex	. last birthday) Yrs.	If Under Months		If Under 24 Hours	4 Hrs. Min.	8. Date of Birt (Month, Day 10/28	r, Year)	Co	thplace (State or Foreign ountry) orgia
	land		Usual Residence of Decedent  10a. State 10b. County P	rince. 10c. C	ity, Town or Lo	cation							10d. Inside City Limits
	Mary	ō	MD G	rince's U	pper M	arlb	oro						1 X Yes 2 □ No
	th the	Director	10e. Street and Number			10f. Zip	Code				10g. Citizen of	Whal Co	ountry?
	23a data	rai	8904 Pensacola	Place		2	0772				USA		
21215-0036	within 72 hours after death with the Maryland ane. than "natural", or Iteme 23s or 28s-1 show he Misciegal Externing travet be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in t Armed Forces? 1 ☐ Yes 2₹ No If Yes, Give Year or Dates:	1	Was Decede f Yes, speci 1 Yes 2	rty Cuban,	anic Origi Mexican, Specify:	in? (Spec Puerto R	offy Yes or No- lican, etc.)	Bla	ce - Ame ick, Whit	
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Maryland	De de la de	To Be	James Goolsby					Rosi	Le W	itche	r		
	is 1 and 2 should of Health and Mer Item 27 is marke other traumatic		19a. Informant's Name/Relationship (7 Dorothy Simpson	n - Daughter	19b. Mailin	90	u va	rney	7 St	reet,		, State, 2 # 3	Zip Code) 09
Baltimore,	permit. Pages 1 Department of H Important: If Itel eny injury or ott		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specify	Removal from State	cemetery, cren	natory or oth	her place)	- 1			20c. Location		Town, State
Balti	permit. Departn Importe eny inju		21. Signature of Funeral Service Licen	illians	22 L	. Name and atne	Address o	of Facility Fune	eral	Home	3831 Wash.	Ga.	Ave. NW C 20011
4			23a Part1. Enter the disease, or comp shock, or heart failure. List only	lications that caused the dea one cause on each line.	th. Do not ente	er the mode	ol dying,	such as ca	ardiac or	respiratory arr	est,		Approximate Interval Between
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P.O. Box	that the death certific ned by the attending p deteched for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒No 9 ☐ Unknown	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c 9 ☐ Unknown	al death 3 🗍	Ectopic pred Other (spec	gnancy crfy)					te ol deli onth	ivery Day Year
œ.	The law requires that the ate has been signed by thi page 2 should be deteche	by P!	Part II. Other significant conditions co	ntributing to death but not res	sulling in the un	derlying cau	use given i	in Part I.		23e. Did tol	pacco use cont	ribule to	the cause of death?
Division of Vital Records,	w require been sig should b	led							_	1 🗆 Ye	es 2 □ No	3 🗆 Pro	obably 4 Unknown
ecc	e law re has be je 2 sho	Completed								24a. Was a		Were au	topsy findings available
<u>ح</u>		Con								autops perform	ned?	death?	completion of cause of 2 \sum No
Vita	Physician: Th this certificate iral director, pag	Be	25. Was case referred to medical examiner?	Una-itali			_	6. Place of	f Death (	Check only on			
<b>o</b>	Phys rthis ral dir	. 70	1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 2 ☐ 28a. Date of Injury	ER/Outpalient 28b. Time of						ence 6 □Oth		cify)
on	After fune	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	м 280	c. Injury at Work?	2 <u>□</u> No		d. Describe ho	ow injury occuri	ed	
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	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edicai (	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best of my kno iner: On the basis of examina and manner stated.	owledge, death tion and/or inv	occurred at estigation, in	the time, on my opinion	date and pon, death	place, an	d due to the ca at the time, da	ause(s) and ma ate and place,	nner as and due	stated. to the cause(s)
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}	6		) /m	1100		D	005	79:	28		11/1	6/05	5
カ	1		30. Name and address of person who c			Print) D	MASO	ל מסי	A NEW P	r_	*	•	
1			1328 Southern A		214 -	WASI	HING	TON,	DC				
	Sta Registra		31. Date filed (Month, Day, Year)	32 Aegistrar's Signa	The Age	west !							,

_			1 - State Registrar	State of Maryland /		artment of Health rtificate of Deati			giene 005	3799	90
	Physici	ian	1. Decedent's Name (First, Middle, Last)				2	2. Date of Dea Month	ath Day Year	3. Time of D	
1	/Media	ical	Lillie Graves  4a. Facility Name (If not institution, give str			· · · · · · · · · · · · · · · · · · ·			15, 2005	5:11	AM
1	Examin	ier	Southern Marylar			4b. City, Town, or Location Clinton	in of Deatri		4c. County of Dec		
T	Funeral		Social Security Number 6. Sex	7. Age (In yrs. last I		If Under 1 Year If Under	der 24 Hrs. 8	B. Date of Birtl (Month, Day		irthplace (State or F Country)	
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•	and		Usual Residence of Decedent  10a. State 10b. County ROC	ckinghamoc. City, To	own or Lor	cation				10d. Inside City	
	Many Many	į	NCarolina	- 1		le, North	Carol	ina		1 XYes 2	,
	th with the	Funeral Director	10e. Street and Number 505 South Tiptor	n Street,		10f. Zip Code 27320			10g. Citizen ol What C USA	ountry?	
136	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 ehow any Injury or other traumatic event. The Medical Examinar must be mailled at ONGE.	by Funer	11. Marital Status 12  1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 [X]No If Yes, Give Year or Dates:		Vas Decedent of Hispanic C Yes, specify Cuban, Mexica □ Yes 2 No Specify		ify Yes or No- can, etc.)	14. Race - Am Black, Wh		
8	2 hour	ted t	15. Decedent's Educat	ation 16	6a. Decede	ent's Usual Occupation			16b. Kind of Business		
Maryland 21215-0036	d within 72 giene. er then "n:	Completed by	(Specify only highest grade of Elementary/Secondary (0-12)	College (1.455.)	(Give k. life. Di	kind of work done during mo OO NOT use retired) OORY WORKER	ost of working		Tobacco		ry
pu	be file ta! Hy d oth	BeC	17. Father's Name (First, Middle, Last)						Maiden Sumame)		
yla	1 Meni 1 Meni narke natic	5	George Washingt				zzie				
Ma	d 2 shith and 27 is m		19a. Informant's Name/Relationship (Type) Dr. Wesley A. Bo		9b. Mailing 1538	g Address (Street and Numb 8th Stree	nber or Rural F	Route Number	r, City or Town, State,	Zip Code) 2 N N 1	ľ
ē,	f Heal frem? other		20a. Method of Disposition	20b. Place		sition (Name of patory or other place)	Date	-	20c. Location - City or		
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Baltimore,	permit. Departn Imports any Inji		21. Signature of Funeral Service Licensee		22.	Name and Address of Fact 831 Georgia	olity Lati	ney's	Funeral	Home	
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S, D	res that igned b be deta	by Pt	Part II. Other significant conditions contrib	buting to death but not resulting	j in the unc	derlying cause given in Part	t I.	23e. Did tot	bacco use contribute to	the cause of deat	th?
Sras	w require been sig should b	ted	DEMENTIA					1 □ Y€	es 2.0MAo 3.∏Pi	robably 4 🗆 Unk	.nown
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	Physi r this c aral dir	2	1 193 5 100	spital: 1 npatient 2 ER/O	Outpatient				ence 6 Other (Spe	cify)	
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ב <u>ֿ</u>			4 Homicide determined	28e. Ptace of Injury - At home, f building, etc. (Specify)				City or Town			
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0			30. Name and address of person who comp		) (Type, Pr	ENTRAL A	W. #	301	LAND OI	IER MUZO	0785
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		For	•	•		and / De	epartme	ent of H	lealth a	and M	lental Hy		•		27001
		1 - State Registrar					Certifica	ate of L	Death			Reg. N	,UU	}	37991
Physicia		1. Decedent's Name (First, M. RICHARD S	TEVEN	BR	OWN						2. Date of Do Month Novemb	D.	Ž4, 2č	<sup>'ear</sup> 5	3. Time of Death 3:45 P. M
/Medic Examin		4a. Facility Name (If not institu	ition, give str	reet and nun	nber)		4b. C	ity, Town, or	Location	of Death		4	c. County of	Death	
	4	700 West Bel				t. 324		Abero					Harf		
Funeral Director	ý.	5. Social Security Number 213-28-8982	6. Sex	M 2□F	7. Age (In ) 74	rs. last birthe Yr	Monti	der 1 Year ns Days	If Under Hours	Min.	B. Date of Bi (Month, D May 17	ay, Year	7 1	Cour	place (State or Foreigr ntry) yLand
and w		Usual Residence of Decedent 10a. State 10b. Cou			10c.	City, Town o	or Location							1	IOd. Inside City Limits
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r dea	Funeral	11. Marital Status	t2	2. Was Dece Armed For	ces?	n U.S.	13. Was De If Yes, s	cedent of Hi pecify Cuba	ispanic Ori ın, Mexicar	igin? (Spe n, Puerto	cify Yes or N Rican, etc.)	0-	14. Race - Black,	Americ White,	
s afte	by Fu	1 ☐ Never Married 2 ☐ Never M		1 √Yes If Yes, Giv Year or Da	2∐No Bose Ko	rean	1 🗆 Yes	2 <b>X</b> No	Specify:	:			Specify:	L.T.	hite
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그 문문을		11. Signature of Funaral Say		•		I CCII I	22 Name	and Address	ss of Escili	tv.					aryraid
Department Department Important ir mportan		Levre A	, Fe	nai	re		M1 EC	neli-w York	viede. C Roa	d Ba	Funera altimor	e. H	ome, l Marvla	nc. ind	21212
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To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: Atter this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE:													
oth ce	an/l	23b. Was decedent pregnant in the past 12 months?	230	c. If yes, out 1 ☐ Live bi	ome of pre		3 □Ectopi	pregnancy	•				23d. Date of		ery Day Year
the a	/sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4□Pregna 9□Unkno	ant at time	of death	5 Other	(specify)					11101111	,	July Four
that the ed by detac		Part II. Other significant con	ditions contr	ributing to de	ath but not	resulting in t	ne underlyin	g cause give	en in Part I	 I.	23e. Did	tobacco	use contrib	ute to t	he cause of death?
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ysici nis cen i direc	ToE	examiner? 1 Yes 2 No	Но	spital: 1 🗆 li	npatient 2	2 🗆 ER/Outp	atient 3	DOA Othe	er: 4 □ Nu	ursing Hor	ne 5 Pes	idence	6 ☐Other	(Specif	(y)
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tendi feath. tor: A the fi	cati	2 ☐ Accident Inv	estigation uld not be	22 - 51	-41-1		M		Yes 2 🗌		206 1	/C++			70
or All after of Direction by	Certification:	4 Homicide de	ermined	28e. Place buildir	of Infury - Fing, etc. (Sp	At home, farm ecify)	i, street, fac	tory, office			City or To	wn, Sta	na Number te)	or Hura	al Route Number,
To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier 1 Cert	fying Physic	cian: To the	best of my	knowledge,	death occur	ed at the tim	ne. date ar	nd place, a	and due to the	cause(	s) and mann	er as s	tated.
1 24 h	edicai	(Check only 2 Medi	cal Examine	er: On the ba	isis of exam	nination and/	or investigat	ion, in my op	pinion, dea	alh occurr	ed at the time	, date ar	nd place, and	due to	the cause(s)
To th Withir To th comp	×	29b. Signature and title of cer	tifier	1				29c. License	e number			29d. D	ate signed (	Month,	Day, Year)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend items 10h 16a 22/per The 849 11 28-05 yr

Later of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. U 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 905 **Physician** BEIL LESSIE 2000 NEVENERE /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 45 5 TAL RANDAKSTENON GENTEN BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2**[**] F 72 224-40-4224 Director Virginia 29,1933 Dct Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or Itams 23a or 28a-f show N/A Maryland 1 Yes 2 No Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? #304 6520 Eberle Drive USA 21215 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: SpecifyBlack 9 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within 7 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Good Samaritan Hosp Housekeeping 11th grade ges 1 and 2 should be filed at of Health and Mental Hygis If item 27 Is marked other Housk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ernest Goode Louise Newsome 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Bural Royte Number, City or Town, State, Zip Code) 21215 6520 Eberle Drive #304 Baltimore Maryland Charles Bell/ Husband Baltimore, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 11/26/05 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
eny injury or ott 1 ☐ Burial 2XI Cremation 3 ☐ Removal from State Greenmount Cemetery 4 □ Donation 5 □ Other (Specify) Baltimore,Maryland 21. Signature of Jun ral Service Licen & 5240 Reisterstown Rd. Balto, Md. 51415 reisters
Chatman-Harris Funeral Home
Chatman-Harris Funeral Home 23a. Part/ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest speck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final SEPSIS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine attending physician and for use as the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ Fishela 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an SECEN DANCY autopsy performed DENIEN TIA 1 ☐ Yes 2 € No 1 Yes 2 No Division of Vital To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No 1 Tes 1 patient 2 ER/Outpatient 3 DOA After thi funeral o 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No М investigation death 2 Accident Director: filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after of To the Funeral Direct completely filled in by 4 THomicide 1 Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier b

Registrar DHMH 17 Rev 1/2001

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (0

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32. Segistrar's Signature

 $\mathbf{E}\mathbf{M}$ 5-07879 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Unpend Item 23a,27,28a-f per me G850 12-19-05 tas
Registrar Shefronya Barrett 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year zerett **Physician** 0 rou 2005 1:35 P November /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner <u>Baltimore City</u> 4604 Haddon Ave If Under 1 Year If Under 24 Hrs Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, 5. Social Security Number **Funeral** Days 1 □ M 2 X F 435 216-78-1 Yrs and Director may 8, 1960 men Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County r then "naturel", or Iteme 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 □ No MO Director the 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code 10 Funeral 12. Was Decedent Ever in U.S. Armed Forces?, 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after Black 1 Never Married 2 Marned 1 ☐ Yes 2 No Maryland 21215-0036 Specify Specify: 4 Divorced þ 3 Widowed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) てんひ Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 1an cla th and Mental Hygier is marked other th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last, Be should be arrett la ovar d 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an farents Item 27 is allo . 2120 Howard + C ar Dervet -4604 add ind Baltimore, Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages Depertment of Importent: If It eny injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 29 05 rordlaun ovalla 4 Donation 5 □ Other (Specify) (em M 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Dalto ind, 21229 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Methadone intoxication disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Iner law requires that the death certificate be executed Exam burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Month Day Year ₫ in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) the o detached 9 Unknown 9 Unknown ۵ ۵ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, δ 3 Probably 4 Unknown 1 Tes 2 🗌 No should Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificete has autopsy performed 2 No 1 🗹 Yes of Vital 26. Place of Death (Check only one, uneral director 25. Was case referred to medical Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Scene 1 XYes 2 🗌 No 2 ER/Outpatient 3□ DOA Certification: To this 28a. Date of Injury
(Month, Day Year)
Found:
11-22-05 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 28b. Time of unk unk After Injury Division Attending 1 Natural 5 Pending 1 ☐ Yes 2 📉 No investigation 6 Could not be within 24 hours after death. To the Funers! Director: A 2 Accident completely filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4604 Haddon Ave. 3 TSuicide determined 4 Homicide ö Home Baltimore, MD 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 290. Signature and title of certifier

31. Date filed (Month, Day, Year)

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and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registr

's Signature

DHMH 17 Rev 1/2001

29c. License number

OCME

Penn Street, Baltimore, Maryland 21201

29d. Date signed (Month, Day, Year)

November 23, 2005

			1 - For State Registrar	State of Ma		d / Depa	artme		alth and M	Mental Hy	/gien	e 2009	5 3	7991.
~			Decedent's Name (First, Middle, Las	t)						2. Date of D	eath		3. 1	ime of Death
	Physici		FRANK JAMES	BAIE	R. J	R.				NOV.	25,	2005 <sup>°</sup>	ar 1:	:45 p <sup>M</sup>
>	/Medic Examin		4a. Facility Name (If not institution, give		-1		4b. Cit	y, Town, or Lo	cation of Death	)		. County of I	Death	
		> ≪	GENESIS HEALTHO	CARE				BROOKI	LYN		A	NNE A	RUNDI	ΞL
7	Funeral		Social Security Number     6. Security Number			ast birthday)	If Und		Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D FEB.	irth av. Year	9.		State or Foreign
	Director		216-34-4458	<b>Ç</b> M 2□F	69	Yrs.			10010	FEB.	2,1	936 M	IARYĹ	AND
	pu >		Usual Residence of Decedent  10a. State 10b. County		10c Cib	, Town or Lo	cation						10d In	side City Limits
	shov	2						5						Yes 2 No
	188a-f	ecto	MD. N/A			BALTI		Lip Code			10a C	itizen of Wha	t Country?	
	a or	ā		maadmo			101. 2		. 4		-		-	
	d within 72 hours after death with the Maryland jiene. r than "neturel", or iteme 23a or 28a-f show the Micdical Examiner must be notified at	Funeral Director	712 S. GRUNDY	12. Was Decedent I	Ever in U.	S. 13. 1	Was Dec	2122 edent of Hispa		pecify Yes or N		U.S.A 14. Race	American Inc	dian,
_	ter d	F	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🔀 N If Yes, Give						pecify Yes or N o Rican, etc.)		Black, \	White, etc.	
0000	hours after turel', or its at Examina	by	3 ☐ Widowed 4 X Divorced	If Yes, Give Year or Dates:			1 ∐ Yes	<b>X</b> □ No S	ipecity:			Specify:	WHITE	2
<u>ဂ</u>	2 ho	ted	15. Decedent's Ed (Specify only highest gra	ucation		16a. Dece	dent's Us	ual Occupation	n ng most of wor	kına	16b. h	Kind of Busin	ess/Industry	
<u> </u>	within 72 ene. than "nel	npie	Elementary/Secondary (0-12)	College (1-4or 5	+)	life.	DO NOT	use retired)		9				
Z	ed wi	Completed	12			MACH	INE	OPERA				TERN	ELECT	RIC
and	d oth	Be	17. Father's Name (First, Middle, Last)							ne (First, Middle	e, Maidei	n Sumame)		
<u>X</u>	D 2 3 0	2	FRANK JAMES	BAIER, S	SR.					CULLEY				
Маг	2 sh and 1 mm		19a. Informant's Name/Relationship (7				-			ral Route Numl				
e,	s 1 and 2 show I Health and M Item 27 le mar other treumat		JOAN TUROWSKI/ 20a. Method of Disposition	SISTER	20h P	/ U U			STRE	ET, BAL		ORE, M.		
	H ite		1X Burial 2 ☐ Cremation 3 ☐		a	emetery, crei	matory o	other place)						
Baltimor	rtant rtant		4 Donation 5 Other (Specify		GA.				11/3					RYLAND
a n	Department of the poor of the		21. Signature of Funeral Service Licen	500		J L	TLL	Z ZE	ILER	INC. F	UNE	RAL H	OME	
			23a Part1 Enter the disease or com	plications that caused	the death							ALT.TW	Appr	ID. 212
	, 100 200 4		23a. Part1. Enter the disease, or compshock, or heart failure. List only Immediate Cause (Final											val Between et and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as			ER'	5 1	EMB	NTIA				
	Examiner			Due to (or as	a consequ	derice of).								
١.		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as	a consequ	uence of):								
	d d ansit	Examiner	Cause (Disease or injury that initiated events	C										
o Î	ite be executed sysician and ne burial-transit		resulting in death) Last	Due to (or as	a consequ	uence of):								
2/60	ate be nysici ne bu	icai	•	d										
9	The law requires that the death certificat ste has been signed by the attending phy page 2 should be detached for use as th	by Physician/Med	IF FEMALE:											
ХOЯ	th ce tendi	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1☐Live birth		death 3		pregnancy				23d. Date of Month	f delivery Day	Year
o.	the at	sici	1 Yes 2 No	4☐Pregnant at 9☐Unknown	time of de	eath 5	Other	specify)				worki	54,	
7	d by letach	Phy	Part II. Other significant conditions of	notabuting to death b	ut not roo	ultipa in the u	n doch in	ogues gwan i	n Barti	23a Did	tobacco	use contribu	ite to the cau	is a of death?
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0	w requires that the de been signed by the a should be detached	Completed	14014 71474 6114	Dillip	2   12	> 11	16	- 4114			1 103 2	100 00		7,40
ec	alaw nasb e 2 sl	npie								24a. Wa	opsy	prio	r to completi	ndings available on of cause of
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Vital Records,	Attending Physician: The death. ector: Alter this certificate by the funeral director, pag	Be	25. Was case referred to medical examiner?	Hospital:					6. Place of Dea	ith (Check only	one)			
	hys this	ပို	1 ☐ Yes 2 No	1   Inpatie		ER/Outpatier		_	/ -	ome 5 Res			Specify)	
Z C	line une	on	27. Manner of Death  1 ⊠Naturat 5 □ Pending	28a. Date of Inju (Month, Da	y Year)	28b. Time o Injury	M	28c. Injury at Work?		28d. Describe	now inju	ury occurred		
20	death death tor: the	cat	2 Accident investigation 3 Suicide 6 Could not b		unu - At ho	mo larm et			2 □ No	28f. Location	(Stroot a	nd Number	or Pum I Pou	te Number
Division of	i Diffe	Certification:	4 Homicide determined	building, et			reet, ratti	ory, office		City or To			or nurar nou	10 140111001,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi		(Check only 2 Medical Exar	ysicien: To the best niner: On the basis o	examina	wledge, deat tion and/or in	h occurr	ed at the time, on, in my opini	date and place on, death occu	, and due to the irred at the time	e cause(s	s) and manne	er as stated.	ause(s)
	To the P within 24 To the F complete	Medicai	one) 29b. Signature and title of certifier.	and manner sta	ated.			29c. License ni				ate signed (A		
	To Yell		230. Signature and title of certains	1		A A T	,	~						
P		2	The state of the s	~~~ Z		10(1)	Date	1) 51	596		NOV	<b>GMBE</b>	R 28	,2005
4	1	1	30. Name and address of person who	completed cause of c				100	1,50	BURNI	6	MA	2114	•
	St.	ate	31. Date filed (Month, Day, Year)	32. Registr					MUDIN	OWKIYI	12	( )	2100	
	SinaR teinaR			2000		10	brace							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2005 1 - For State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Joseph Edward Brietenback, Sr. 3:30 PM 4)9 2005 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State Country) April 23, 1931 Maryland Birthplace (State or Foreign Country) 213-28-7461 1**∑**M 2□F Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Md. Harford Bel Air 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 804 Deepwood Court 21015 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify: white 3 ☐ Widowed 4 ☐ Divorced Specify: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coltege (1-4or 5+) 8 years <u>steelworker</u> stee1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Brietenback Agnes C. Lusby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Timothy Brietenback/son 804 Deepwood Court, Bel Air, Md. 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Holly Hill Mem. Gdns. 11/26/2005 4 □ Donation 5 □ Other (Specify) Middle River, Md. 21. Signature of Euperal Survice Licenses 22. Name and Address of Facility
Schimunek Funeral Home of Bel Air, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.

Approximately 1014. Approximate Interval Between Onset and Death Immediate Cause (Final Cardiores piratory
Due to (or as a consequence of): disease or condition resulting in death) 5 m 7 weeks piration Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (orus a consequence of). Coroted IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day 4☐ Pregnant at time of death Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1□Yes 25 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Inpatient 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending Injury investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Momicide

/Medical Examiner anding physician and use as the burial-transit or Attending Physician: The law requires that the death certificate be executed after death. Division of Vital Records, P.O. Box 68760, certificate this After thi Director: / within 24 hours after d To the Funerel Direct completely filled in by o the Hospitel

**Physician** 

/Medical

Director

Completed by Funeral

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Examine

Physician/Medical

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Certification:

29a. Certifier

Examiner

**Funeral** 

Director

other traumatic event, the Macical Examiner must be nutified at

or Iteme 23a

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al Hygiene.

permit. Pages 1 and 2 should be file.
Department of Health and Mental Hyg Important: If Item 27 is marked othe any lightry or other treumatic event, 9058.

**Physician** 

Baltimore, Maryland 21215-0036

back

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State Registrar 29b. Signature and title of certifier Gedron Atnope 29c. License number D0062148

texcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated [2] Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

11/22/05

Attenborough Dr. #

304

Baltimore,

Gedion Atnafu, M.D. MD

31. Date filed (Month, Day, Year)

32. Registrar's Signature Elegen S. Spark

			For State Registrar	State of	Marylar	-	artment of I rtificate of			R	eg. No.	05	37996
	Physici	an	1. Decedent's Name (First, Middle, La Roderick A. B							Date of Deat Month Ovember	Day	2005	3. Time of Death 05:39 A M
	/Medio Examir		4a. Facility Name (If not institution, give		nber)		4b. City, Town,	or Location o				nty of Death	
			GREATER BALTIMO				TOWSON If Under 1 Year	If Under 2	74 Hrs. Lo.	Data of Bigh		IMORE	
	Funeral Director		5. Social Security Number 6. S 2 1 9 - 6 8 - 1 8 1 3	Sex IM 2□F	7. Age (In yrs. 44	Yrs.	Months Days		Min	Date of Birth (Month, Day, 3 / 1 1 / 1	Year) 1 9 6 1	9. Birth Cou M [	place (State or Foreign ntry)
			Usual Residence of Decedent			ty, Town or Lo							10d. Inside City Limits
	Aarylan I show	ō	10a. State 10b. County MD NA			altim							1 X Yes 2 No
	ith the M or 28a-f	irect	10e. Street and Number			aitim	10f. Zip Code			1	0g. Citizen	of What Cou	ntry?
لمنہ	death with the Maryland ms 23a or 28a-f show (must be notified at	ralD	408 Allendale				2122				US		
. 2	after dea or items	nue	11. Marital Status  1	12. Was Dece Armed For 1  Yes	dent Ever in U ces? 2 DXNo		Was Decedent of If Yes, specify Cub		gin? (Specif i, Puerto Ric	y Yes or No- an, etc.)		Race - Amen Black, White Afr	etc.
164	ours af	Completed by Funeral Director	3 Widowed 4 Divorced	If Yes, Give Year or Da	8		1 ☐ Yes 2 🂢 No	Specify:			Spe	CITY:	rican
	72 hours "natural",	letec	15. Decedent's E (Specify only highest gr			(Give	dent's Usual Occu kind of work done DO NOT use retire	during most	of working		16b. Kind o	f Business/Ir	dustry
7212	e filed within al Hygiene. other than *	ошо	Elementary/Secondary (0-12)	College (1	-4or 5+)		erer	,,,,			Class	s Act	Catering
P	be filed tal Hyg d other	Be	17. Father's Name (First, Middle, Last							irst, Middle, M	Maiden Sum		
2 N	should be nd Menta marked imatic ev	2	James Britton  19a. Informant's Name/Relationship			10h Mailie	ng Address (Stree			Brit		un Stata Zi	n Code)
Mai	2 2 20 20		James Britton				Allenda	_					
ore,	es 1 and 3 of Health fitem 27 r other tr		20a. Method of Disposition  1			Place of Dispo	sition (Name of matory or other pla		Date			on - City or T	
Baltimor	Pages tment o tant: If		4 □Donation 5 □ Other (Speci	fy)	Kir								cown, MD
Ball	permit. Pag Department Important: I any Injury o		21. Signature of buneral Service Lice	nsee	1		200 Lib						P.A.ofB. MD 21133
			23a art1. Enter the disease or conshock, or heart failure. List only	polications that ca	aused the deat							1	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	- a		12 .	MONIA	A					Onset and Death
	/Medical Examiner		resulting in death)	h	or as a consec				54 1 1 C	1/20	10		1 55:06
8	**************************************	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	0	OMAY or as a consec	juence of):	NUNDA	TIME	NUT	VIC	/L>		WEEKS
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P.O. Box 68760,	tificate ig phys as the			d									
30 X	eath certif attending for use a:	lan/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		rth 2 Feta	aldeath 3□	Ectopic pregnanc	у				Date of deliv Month	ery Day Year
0	the dei y the a ched f	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregna 9⊟Unkno	ant at time of o	leath 5	Other (specify) _						
		by Physician/Med	Part II. Other significent conditions	contributing to de	eath but not res	sulting in the u	nderlying cause g	ven in Part I.		23e. Did tob	oacco use c	ontribute to t	the cause of death?
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ž	hysicle this cer al direct	To B	examiner? 1 ☐ Yes 2 ☑ No	· · · · · · · · · · · · · · · · · · ·	· <u>··</u>	ER/Outpatier	11 30 DOA	her: 4 □ Nu		5 🗆 Reside		Other (Speci	fy)
0 10	ding Physiclen: The h. h. After this certificate hit tuneral director, page	lon:	27. Manner of Death 1 ★Natural 5 □ Pending		of Injury h, Day Year)	28b. Time o Injury	Wo	ıryat ork? ]Yes 2 □ !		d. Describe ho	w injury occ	curred	
Division of Vital Records,	of or Attendiate after death.  Director: A in by the fu	ficat	2 Accident Investigation 3 Suicide 6 Could not to determine	28e. Place	of Injury - At h	ome, farm, str	eet, factory, office			. Location (St	reet and Nu	mber or Rur	ai Route Number,
Δ	- 9	Certification:	4  Homicide determined	buildir	ng, etc. <i>(Speci</i>	ry) 				City or Town	, State)		
	Hospi 24 hou Funer tely fill	Medical	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa		sis of examina		h occurred at the t vestigation, in my						
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	Mec	29b. Signature and title of certifier	and main			29c. Licen	se number		2	9d. Date sig	ned (Month,	Day, Year)
	/		> Kolapan	N	VD.		Do	0615	119		11/2	1/20	05
in	$\triangleleft$		30. Name and address of person who	completed cause	Thi 1		Print) ARUES	4.B.	M.C	E 42	17	h 1 1	21204
9	Sta	ate	31. Date filed (Month, Day, Year)	32. R	strar's Sign		1	011	0011	E 72	-( 1.	NI D	1204
	Regist	rar	NOV 2 8	2005 A	Ball AR.	1. 1	COLLE						

		1 - State of Maryland / Description 1 - State of Maryland / Description 2, 17, 26 per physish of Particle 1. Decedent's Name (First, Middle, Last)	ertificate of Death	Re 2. Date of Death		3. Time of Death
Physici		MARY	BARNETT	NOVEMBER	R 2005	3:20 P M
/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Deat	th	4c. County of Dea	
		6101 NEILWOOD DRIVE	ROCKVILLE  JI Under 1 Year   If Under 24 Hrs	O Date of Birth	MONTGOM	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthd	Months Days Hours Min		907	thplace (State or Foreign buntry) MD
pu *		Usual Residence of Decedent         10a. State         10b. County         10c. City, Town o	Location			10d. Inside City Limits
death with the Maryland ims 23a or 28e-f show	ō	MD MONTGOMERY ROCKV				1 Tes 2 No
r 28e-	Director	10e. Street and Number	10f. Zip Code	10	og. Citizen of What Co	ountry?
23a o		6101 NEILWOOD DRIVE	20852		U.S.	
or ite	by Funeral	11. Marital Status  1 □ Never Married  3 및 Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 및 No If Yes, Give X Year or Dates:	3. Was Decedent of Hispanic Origin? (Solif Yes, specify Cuban, Mexican, Puer 1 Yes 2 No Specify:  1 Yes 2 No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whi Specify: WH	te. etc.
65 (24	eted	(Specify only highest grade completed) (G	cedent's Usual Occupation ive kind of work done during most of wo	orking	16b. Kind of Business	/Industry
giene. er then "n	Completed	Flementary/Secondary (0-12) College (1-4or 5+)	e. DO NOT use retired)  KKEEPER		HIFI RECO	RD SHOP
Hygi other ant, L	e Co	17. Father's Name (First, Middle, Last)  Isreal Goldman		me (First, Middle, M		10 01101
a de la	ToB	Isreal Goldman GOLDM	AN SARAH		GOL	DMAN
a se	· [		ailing Address (Street and Number or R		·	
item 27 other tr		20h Place of Di	1 NEILWOOD DRIVE -		E, MD 208	
O == ==		1 67 Burial 2 □ Cremation 3 □ Removal from State  1 □ Cremation 3 □ Removal from State  1 □ Cremation 3 □ Removal from State  1 □ Cremation 3 □ Removal from State  1 □ Cremation 3 □ Removal from State  1 □ Cremation 3 □ Removal from State  1 □ Cremation 3 □ Removal from State  1 □ Cremation 3 □ Removal from State  1 □ Cremation 3 □ Removal from State  1 □ Cremation 3 □ Removal from State  1 □ Cremation 3 □ Removal from State  1 □ Cremation 3 □ Removal from State  1 □ Cremation 5 □ Cremation 3 □ Removal from State  1 □ Cremation 5 □ Cremation	PARK	20/2005 F	RANDALLSTO	LIN MD
Department Importent: eny injury c		21. Signature of Funeral pervice Licensee	22. Name and Address of Facility		ON & BROS.	
Depa Impo eny ii		· Ga	8900 REISTERSTOWN	ROAD - PI	KESVILLE.	MD 21208
hysician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or healt failure. List only one cause on each line.  Immediate Cause (Final disease of condition resulting in death)	enter the mode of dying, such as cardial to Leave Face kin	c or respiratory arre	est,	Approximate Interval Between Onset and Death
Examiner		Due to (or as a consequence or).	Fiballet			245
-	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	, , , , , , , , , , , , , , , , , , , ,			1
sician and burial-transit	Examine	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	•			
sician	dical E					
g physi	edic	g				
by the attending pt tached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 Dectopic pregnancy 5 Other (specify)		23d. Date of de Month	livery Day Year
gned be de	by Ph	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.		pacco use contribute t	
been si should l	ted					robably 4 Unknown
S C4	Completed			24a. Was ar autopsy perform	y prior to death?	utopsy findings available completion of cause of s 2 No
certificate har rector, page	Be Co	25. Was case referred to medical	26. Place of De	1  Yes 2 eath (Check only one		5 2 140
this cer al direc	ToB	examiner? 1 Yes 2 Wo Hospital: 1 Inpatient 2 FeVOutpa			nce 6 □Other (Spe	ecity)
After th uneral		27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) Inju		28d. Describe ho	w injury occurred	
within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, larm building, etc. (Specify)		28f. Location (Str City or Town	reet and Number or R n, State)	ural Route Number,
4 hours Funere ely fille	Medical C	29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/o				
vithin 24 hours a	Med	one) and manner stated.  29b. Signature and tipe of pertifier	29c. License number	29	9d. Date signed (Mon	th, Day, Year)
s ⊢ ŏ		I ( Clar Le	196611			
0		30. Name and address of person who completed cause of death (Item 23a) (Ty	# 306 SI MO	AL	an JC4.	re lile.
Sta	ate	30. Name and address of person who completed cause of death (Item 23a) (Ty Act 23a). Date liled (Month, Day, Year)  32. Registrar's Signature	nach s	<i>V</i> . C	- C GC Y	2100
	rar	NOV 2 8 2005 Blow 15 19	Company of the Compan			

			1- For Amend Item 8 per fh G849 II-28-05 Registrar		27000
			Decedent's Name (First, Middle, Last)	2. Date of Death	3. Time of Death
	Physici		PEGGY R	BERESON NOVEMBER 24 2005	2:48 A M
	/Medio Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death  4c. County of Death	2.40 N
1			3610 GARDENVIEW ROAD	BALTIMORE BALTIMORE	:
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year   If Under 24 Hrs.   8. Date of Birth 1 - 27-1928 inthat	ace (State or Foreign
	Director		217-24-0/29 10 M 2 XF 76 Yrs.	Months Days Hours Min. 1 Month Day Rad Count	MD MD
	and *		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Lo	ocation	
	Aarylan f show	0			0d. Inside City Limits  1 Yes 2 No
	the A	Director	MD BALTIMORE BALTIMO  10e. Street and Number	10f. Zip Code 10g. Citizen of What Count	
	hours after deeth with the Maryland turel', or Items 23a or 28e-f show al Examiner must be notified at		3610 GARDENVIEW ROAD	21208 U.S.A.	ry:
	ns 2;	Funeral	11 Marital Status 12 Was Decedent Ever in U.S. 13 V		an Indian
ယ	ifter (	포	1 Never Married 2 Married 1 I Yes 2 N No	If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  Black, White, e	etc.
ğ	rel', o	þ	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 🕅 No Specify: Specify: WHI	IE
21215-0036	72	Completed	15. Decedent's Education 16a. Deced (Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of working	ustry
2	within ene.	ğ	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)	
2	ifiled within Hygiene. other then rent, Ine M			SPERSON JEWELRY	
Maryland	0 ta 2 0	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Sumame)	IDIID
Z	d 2 should be th and Menta 7 Is marked treumatic ev	၉	SAUL ROBERT LEVINSO  19a. Informant's Name/Relationship (Type, Print)  19b. Mailir		IDUR
Za	d 2 s th ar 7 is treu	8 1		ng Address (Street and Number or Rural Route Number, City or Town, State, Zip ( WILTONWOOD ROAD - STEVENSON, MD 2115	·
ē,	1 al Hea em the		20a. Method of Disposition 20b. Place of Dispo	osition (Name of Date 20c Location - City or Tow	
9	000		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State  1 ☑ Donation 5 ☐ Other (Specify)  BETH JACO	matory or other place)	
Baltimore,	permit. Pag Department Important: I any injury o		BEITI ONCOL	2. Name and Address of Facility	
ä	P P E S	1 1	Acott M. Withen	SOL LEVINSON & BROS.,	
			23a. Part1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause an each line.	8900 REISTERSTOWN ROAD - PIKESVILLE, er the mode of dying, such as cardiac of respiratory arrest,	MD 21209 roxima e Interval Between
	Physician		Immediate Cause (Final disease or condition Purpose Tac	hacardas	Onset and Death
4	/Medical		resulting in death)  aue to (or as a consequence of):	(a. a.d.	30 000
	Examiner		Sequentially list conditions. b. Whay ay	huy disease	10 9001
1/	sit s	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		
8	and I-tran	Examin	that initiated events resulting in death) Last C. Due to (or as a consequence of):		
8760,	The law requires that the death certificate be executed at the bas been signed by the attending physician and bage 2 should be detached for use as the burial-transit		out to (or as a consequence or).		
687	licate I physi s the t	edical	d		
Box	death certifica attending plant of for use as t	N/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	23d. Date of delivery	,
	death e atte d for	Physiclan/Me	in the past 12 months?  1 Yes 2 No. 4 Pregnant at time of death 5	IECTODIC DEGUARDOV	Day Year
P.0	that the de ad by the detached	hys	9 ☐ Unknown		
	signed d be del	by P	Part II. Dther significant conditions contributing to death but not resulting in the ur	nderlying cause given in Part I. 23e. Did tobacco use contribute to the	cause of death?
ë	w require been sig should t	ed	Lung Comiter	1 ☐ Yes 2 ☐ No 3 ☐ Probab	bly Unknown
000	e law requ has been je 2 shoul	piet	1	24a. Was an 24b. Were autops	sy findings available
Vital Records,	The are he page	Completed		performed? death?	pletion of cause of
ita	Physicien: This certificaral director, p	Be (	25. Was case referred to medical examiner?	26. Place of Death Check only o )	
£	Physii this c	2	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	t 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)	
n o	ing P	lon:	27. Manner of Death  1 Natural 5 Pending  28a. Date of Injury  28b. Time of Injury  28b. Time of Injury	Work?	
isio	Attending r death. ector: After by the fune	icat	2 \( \text{\text{\lambda}} \text{\text{\text{\lambda}}} \) \( \text{\text{\lambda}} \) \( \text{\text{\lambda}} \) \( \text{\text{\text{\lambda}}} \) \( \text{\text{\text{\lambda}}} \) \( \text{\text{\text{\lambda}}} \) \( \text{\text{\text{\lambda}}} \) \( \text{\text{\text{\lambda}}} \) \( \text{\text{\text{\lambda}}} \) \( \text{\text{\text{\text{\text{\text{\text{\lambda}}}}} \) \( \text{\tt}\text{\text{\text{\text{\text{\text{\text{\text{\text{\te	M 1 Yes 2 No	
Division of	il or Attend after death Director: /	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, streen building, etc. (Specify)	eet, factory, office 28f. Location (Street and Number or Rural F City or Town, State)	Route Number,
_	Hospital or 14 hours after Funeral Directory filled in the		29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death	n occurred at the time, date and place, and due to the cause(s) and manner as state	
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	edicai	(Check only 2 Medicel Exeminer: On the basis of examination and/or invone)	restigation, in my opinion, death occurred at the time, date and place, and due to the	he cause(s)
	To th To th comp	M	29b. Signature and title of certifier	29c. License number 29d. Date signed (Month, Da	ay, Year)
)			I have (order Mi)	10012586 (Md) 11/24/05	_
	12		30. Name and address of person who completed cause of death (Item 23a) (Type, F	Print) <sub>4</sub>	
	1 "			Meraille Md 2093	
	Sta Registra		31. Date filed (Month, Day, Year)  32. Registrar's Signature	All A	
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DRMR 17 Rev 1/200

			ricas	State of Maryla				•	_	•
		•	1 - For State Registrar	Otate of Maryla		rtificate of			2005	37999
	/		Negistrat     Name (First, Middle,	Last)				2. Date of Death		3. Time of Death
	Physici		EDWARD	JAMES		BAVERMA	N	NOVEMBER	24 2005	2:40 P M
EXC	/Medic Examin		4a. Facility Name (If not institution,	give street and number)			or Location of Dea	th	4c. County of De	
		ng Agin	7523 SLADE AVE			BALTIMO			BALTIMOR	
	Funeral		5. Social Security Number 579–18–1677	.0	rs. last birthday) 35 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		1920 9. B	irthplace (State or Foreign Country) MD
	Director		Usual Residence of Decedent	^ _	,,,			JE1 1109	1320	110
	irylan ihow	_	10a. State 10b. County		City, Town or Lo	ocation	- 0. T-110			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	death with the Maryland ims 23a or 28a-f ahow if must be notified at	Director		LTIMORE		104 Zin Code	BALTIMO		g. Citizen of What (	
	with t	Ö	10e. Street and Number 7523 SLADE AVE	MITE		10f. Zip Code	21208		g. Citizen or What	USA
	ns 23	Funerai	11. Marital Status	12. Was Decedent Ever in	U.S. 13.	Was Decedent of I		Specify Yes or No- to Rican, etc.)		nencan Indian,
	or Ital		1 ☐ Never Married 2 🛣 Marrie	Armed Forces?  1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	DMV	1 ☐ Yes 2 🙀 No		to Hican, etc.)	Specify:	WHITE
003	hours after tural', or Ita al Examina	d by	3 Widowed 4 Divorced	Year or Dates:		dent's Usual Occur		1.1	6b. Kind of Busines	
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212	s within jene. r than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	FURR	IER			FUR	
bu	be filed within 72 hours after death with the Marylan Ital Hygiene. It dothar than "natural", or Itams 23a or 28a-f ahow avant, Ina Macilcal Examinar oval be notified at	Be C	17. Father's Name (First, Middle, La	est)				me (First, Middle, M	aiden Sumame)	
yla		2	MORRIS		BAVE		JENNIE		C:	ROSENBERG
Maryland 21215-0036	s 1 and 2 should f Health and Mer ltem 27 is marks other traumatic	î Î	CAROLYN LEE BA					ural Route Number, BALTIMORE		
	s 1 and f Heali ltem 2 other		20a. Method of Disposition		. Place of Dispo	osition (Name of matory or other pla			Oc. Location - City	
BO	m 0		1 🕅 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe	□Removal from State city) / B		LOH CEME	1	27/2005	WOODLAW	N, MD
Baltimore	permit. Page Department Importent: If any Injury o		21. Signature of Funeral Service Li	100		2. Name and Addre		OL LEVINS		
0	20E 29		Mulale 1	Miga		8900 REIS	STERSTOWN	ROAD - P	IKESVILLE	, MD 21208
			23a. Part1. Enter the disease, or or shock, or heart failure. List or			ter the mode of dyi	ng, such as cardia	c or respiratory arres	st,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	con geg	100	flear	1 Paul	luce		
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687	<u> </u>		With the second second second second	d						
Box (	eath certifica attending ph for use as th	n/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre-	gnancy	Ectopic pregnanc	.,		23d. Date of d	,
_	death	Physician/Medi	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time of		Other (specify)	у	· ·	Month	Day Year
P.	The law requires that the death certifica tie hes been signed by the attending ph logge 2 should be detached for use as th	Phy	9 ☐ Unknown  Part II. Other significant condition		resulting in the I	Inderhing cause an	ven in Part I	23a Did toba	acco use contribute	to the cause of death?
	signed be det	d by		obstructiv		lugna	1300	-		Probably 4 □Unknown
Vital Records,	w requir been si should	Completed			•		9	24a. Was an	24b. Were	autopsy findings available
Re	The lav	omp						autopsy perform	ed? death'	o completion of cause of es 2 \sum No
ital		BeC	25. Was case referred to medical				26. Place of De	ath (Check only one		
∑ <	S S	ပ္	examiner? 1 Tes 2 DNo		☐ ER/Outpatie	III JUOA		Home 5 Hesiden		pecify)
on c	ling P	lon:	27. Mann Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day Year	) 28b. Time o Injury	Wo	ryat rk? ]Yes 2 ∐No	28d. Describe hov	v injury occurred	
Division of	Attanding r death. sctor: After by the funer	ficat	2 Accident Investiga 3 Suicide 6 Could no	t be 290 Blood of Injuny. A	t home, farm, st					Rural Route Number,
Ö	el or A	Certification:	4  Homicide	building, etc. (Spe	ecify)	•		City or Town,	State)	
	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	dical		Physician: To the best of my incaminer: On the basis of exam						
	To the H within 24 To the F complete	Medi	one)	and manner stated.		29c. Licens			d. Date signed (Mo.	
	To So	-	29b. Signature and title of certifier.	lesou'MD			6748	1	1125720	
	di		30. Name and address of person w		tem 23a) (Type					
	10		4419 FALL	c 000 for	70 N	10212	11 CA	NIL UB	FROL	)
75	Sta		31. Date filed (Month, Day, Year)	2. Registrar's Sign	nature	N. 19				
100	Registr	ar	NOV 2 8 21	005 January A	5- 15					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Day Year **Physician** BLASS BERNARD NOVEMBER 25, 2005 9:30A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Saint Joseph Medical Center Towson Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | JAN.24, 1922 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 M 2 □ F 83 213-14-2497 MD Director Usual Residence of Decedent Peges 1 and 2 should be filed within 72 hours after deeth with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits Items 23a or 28a-f ehow or other treumatic event, the Mudical Examinar must be notified at 1 ☐ Yes 2 ☑ No To Be Completed by Funeral Director BALTIMORE BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21208 1033 FLAGTREE LANE USA 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No WWII If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 'naturel', or 1 ☐ Yes 2 🔀 No Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ai Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) C.P.A. ACCOUNTING 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) and Mental H **BLASS** SARAH FRIEDLANDER **JOSEPH** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) If item 27 i 1033 FLAGTREE LANE - BALTIMORE, MD 21208 BARBARA BLASS / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State permit. Pege Depertment of Important: If ony injury or once. 4 ☐ Donation 5 ☐ Other (Specify) OHEB SHALOM MEMORIAL 11/27/2005 REISTERSTOWN, MD 21. Signature of Puneral Service Ligensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. las 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease shock, or heart failure. I Immediate Cause (Final **Physician** ACUTE MYOCARDIAL INFARCTION disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CRITICAL AORTIC STENOSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit CONGESTIVE HEART FAILURE Due to (or as a consequence of): Division of Vital Records. P.O. Box 68760. RENAL FAILURE IF FEMALE If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Day in the past 12 months? Month Year 5 Other (specify) ours after death. terel Director: After this certificate hes been signed by the e filled in by the funeral director, page 2 should be detached f 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 ☐ Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 2 ER/Outpatient 3 DOA Inpatient 28c. Injury at Work? 27. Manner of Death ate of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Naturat
2 Accident 5 Pending investigation 1 TYes 2 TNo 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \( \text{Homicide} within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) and manner stated 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 41410 t 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. D. 76.01 32. Registrar's Signature JOGINDER 121 OSLER DRIVE TOWSON MARYLAND 21204 31. Date filed (Month, Day, Year) Carles ! State NOV 2 2005 8 Registrar